The perceptions of sub-clinically anxious children, their parents and teachers, of a targeted intervention based on the '*FRIENDS for Life'* programme.

Adrian Gavin

A participatory action research and constructivist grounded theory-based intervention, by an educational psychologist, to determine helpful and unhelpful factors in targeted group intervention with three anxious primary school girls.

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Abstract

The aims of this research were to explore the perceptions of anxious, reticent children, their parents and teachers of a modified and targeted intervention, implemented by an educational psychologist (EP) and based on the *FRIENDS for Life* programme (*FRIENDS*)(Barrett, 2004). A case study approach was used to gather the data necessary to address the aims. The targeted intervention was delivered weekly by the EP using an integrated, study-specific, participatory action research (PAR) and constructivist grounded theory (Charmaz, 2014) (CTG) approach for data analysis and theory development. Two settings within a primary school were strategically used by the EP to dilute any stigma associated with intervention for the three anxious target group (TG) girls aged between nine and eleven (N=3). The three girls were also participant during the same period in the universal application of the programme with the rest of their class peers (N=9).

The thesis takes as it starting point the fact that anxiety is thought to be one of the most common forms of psychological distress in children and young people (CYP) (Cartwright-Hatton *et al.*, 2004) with prevalence being reported as high as twenty one per cent (Kashani and Orvaschel, 1990) and most studies estimating around ten per cent (Carr, 2006). Fortunately, the school-based programme *FRIENDS for Life, (FRIENDS),* based on Cognitive Behaviour Therapy (CBT) principles, appears to be efficacious both at a targeted and universal level with CYP. Little is known however about this programme's application specifically with sub-clinically anxious CYP who are frequently apprehensive about verbal interaction at school and for whom mild to moderate anxiety is indicated. This study attempts to fill this gap. Modifications were made to the *FRIENDS* programme activities to allow for children's non-verbal programme participation and to optimise the reticent target group children's comfort within the group setting. The role of the EP in building therapeutic alliance with the anxious children was also explored.

Study findings suggest that the intervention was positively perceived by participants and that the children perceived story-writing to be their preferred way of working with *FRIENDS* programme content. The use of the seven principles, based on the acronym PRECISE, was deemed useful to the EP in building therapeutic relationship with the reticent children.

Findings underpin the study's proposal for a conceptual model for EPs involved in group work with anxious children. The proposed 'EPPPE' model describes how EPs can use the PRECISE (P) principles in applying their skills in sensitive Programming (P) within a school community's cognitive Ecological (E) context to support anxious children in targeted intervention.

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Glossary of terms and acronyms

BERA	British Educational Research Association
BASC-2	Behavior Assessment System for Children (2nd edition)
BESD	Behavioural Social and Emotional Difficulties
BPS	British Psychological Society
C1	Child one in target intervention
C2	Child two in target intervention
C3	Child three in target intervention
CAMHS	Child and Adolescent Mental Health Service
CBI	Cognitive Behaviour Intervention
CBT	Cognitive Behaviour Therapy
CFPI	Child Focused Psychological Intervention
CGT	Constructivist Grounded Theory
CPD	Continuing Professional Development
CT	Class teacher who is also the school principal
CYP	Children and Young People
DES	Department of Education and Skills
EP	Educational Psychologist
EPPPE	Educational Psychology's use of the PRECICE principles for sensitive Programming within a cognitive Ecological context
FRIENDS	*FRIENDS for Life*
FFL	*FRIENDS for Life*
HSE	Health Service Executive

LST	Learning support teacher
NCSE	National Council for Special Educational Needs
NEPS	National Educational Psychology Service
P1	Parent of intervention child one
P2	Parent of intervention child two
P3	Parent of intervention child three.
PAR	Participatory Action Research
PDST	The Professional Development Service for Teachers
PSI	Psychological Society of Ireland
RoI	Republic of Ireland
SCAS	Spence Children's Anxiety Scale
SDQ	Strengths and Difficulties Questionnaire
SEAL	Social and emotional aspects of learning
SEBD	Social and Emotional Behavioural Difficulties
SEL	Social and emotional learning
SESS	Special Education Support Service
SOC	Stages of Change
TG	Target Group
TM	Talking Mats
UG	Universal Group
UK	United Kingdom
WHO	World Health Organisation

Chapter 1 Introduction

'*Mental Health is a most important, maybe the most important, public health issue, which even the poorest society must afford to promote, to protect and to invest in'* (World Health Organisation, 2003).

Among a broad variety of mental health difficulties, anxiety disorders are considered the most common form of psychological distress in children (Cartwright-Hatton *et al.,* 2004). Childhood anxiety can be relentless and grow to negatively impact normative, developmentally appropriate activities, relationships and achievements (Coplan *et al.,* 2001). Parents become exhausted from managing their children's sensitivities, and schools frustrated by their intermittent attendance and poor interaction in the classroom (Miller *et al.,* 2010).

This research relates to children in ordinary, mixed, rural, mainstream primary schools in the Republic of Ireland (RoI) who have mild to moderate anxiety and who are as such sub-clinical (i.e. have not yet been referred to health professionals or received a diagnosis of anxiety). As a precise definition of what constitutes sub-clinical anxiety has not been located in the literature this study adopted a multi-informant, pragmatic approach to the identification of three children deemed to show mild to moderate levels of anxiety within their school. The study takes into account the children's adaptive functioning within the school environment, their elevated levels of anxiety on screening instruments and teacher and parent opinion in its identification procedures. The terms 'anxious children', 'sub-clinically anxious children', mild to moderate anxiety and elevated levels of anxiety are used interchangeably in the text. A more comprehensive and critical discussion on the categorisation of anxiety is contained in Chapter 2.

Research consistently finds that sub-clinically anxious children are at risk of developing the above mentioned, more serious mental health, internalising disorders (Banerjee *et al.,* 2001; Goodwin *et al.,* 2004). In school they may easily become "invisible" to teachers and have a negative educational trajectory (Rimm-Kaufman and Kagan, 2005). Few descriptions, however, of how EPs target support for these children have been located.

Parents, schools and society should be concerned about childhood anxiety for a number of reasons. Firstly, there is a strong link between anxiety and depression (Barrett *et al.,* 2006) and Ireland has the fourth highest rate of youth suicide in Europe (Central Statistics Office,

2012). Secondly, the long term cost of anxious children to society is estimated to be twenty times that of non-anxious children (Bodden *et al.,* 2008). Recognising and treating anxiety early may help to ensure that '*as many youths as possible complete high school, college and/or university, and become full participants and contributors to society'* (Van Amerigen, 2003:569).

This chapter sets the scene for an intervention with three sub-clinically anxious children. The study has its genesis in my conversations about one anxious and silent ten year old girl in a primary school which developed into the provision of targeted support for her and two of her peers also showing signs of anxiety at school (i.e. the study's targeted intervention). The programme used in the intervention was also delivered to the three children's nine other mainstream class peers (i.e. universal delivery), during the same time period, in an attempt to normalise the programme for everyone in the fifth grade (i.e. January to June 2014).

This chapter provides a rationale and a description of the philosophical underpinnings for this interpretivist, case-study based research, in which I used grounded theory (GT) and participatory action research (PAR) in the generation of theory. It describes the aims and research questions relating to my intervention in one of my assigned primary schools as an educational psychologist (EP) for the National Educational Psychological Service (NEPS). My understanding of the concept of sub-clinical anxiety is briefly examined. The chapter concludes with a personal and professional biographical account which may help explain my positionality within the study.

Rationale

Internationally, with a rate of 15.4 per cent, children and young people (CYP) in the Republic of Ireland (RoI) have higher rates of mental health disorder than similarly-aged adolescents in the USA (11.2per cent) and the UK (9.6per cent) (The CAMHS Report, Cannon *et al.,* 2013). CYP with anxiety-related conditions are the second most referred group to mental health services in the RoI, after those with attention deficit hyperactivity disorder. The report indicates that sixty two per cent of all children referred to its service were aged between five and fourteen years, and that anxiety disorders represented 16.1 per cent of these referrals.

The needs of anxious children are of concern as they are more likely to experience lower self-worth, difficulties adjusting to school, peer rejection, social isolation, increased teacher attention, academic difficulties and school refusal (Coplan, *et al.,* 2001). Longitudinal research indicates later manifestation as loneliness, depression and early school leaving (Gest, 1997; Van Amerigen *et al.,* 2003). Further, there also appears to be a significant impact of anxiety on speaking behaviours at school (Monroe *et al.,* 1992). Van Amerigen *et al.,* (2003) have found that anxious people cited fear of speaking in front of class and feeling nervous at school as the two most common reasons for leaving school early and not enjoying school.

This study did not focus on children with a pre-existing diagnosis of anxiety. It targeted children at a pre-referral, early intervention level in their primary school. It is acknowledged that telling the difference between normal and pathological anxiety, however, can be particularly difficult in children, as they manifest many fears and anxieties as part of their typical development(e.g. separation anxiety 12-18 months, performance anxiety in primary school, fear of negative evaluation as an adolescent) (Morris and Kratochwill, 1991). Although anxiety symptoms are experienced by most children, and can cause distress, they are for the majority, transient. The problem of distinguishing among normal, subclinical and pathological levels of anxiety is problematic, also, because younger children may lack the cognitive capabilities needed to communicate information in relation to cognition and emotions vital to a clinician in the context of making a diagnosis. Thus, it has been argued that differences in development, like language skills and emotional awareness of what is being experienced, must be carefully considered when assessing anxiety in young people (Campbell *et al.,* 2000).

There are other reasons for justifying early intervention. Alarmingly, research has found that eighty per cent of CYP in need of mental health services do not receive services (Cobham, 2012).Fortunately, there is growing evidence that early school-based programmes can improve students' social and emotional skills, attitude, behaviour and academic performance compared to students who do not complete these programmes (e.g. Durlak and DuPre, 2008). Interventions for these anxious children based on cognitive behaviour intervention principles (CBIs) in particular (Beck, 1979) have growing support internationally (Bernstein, 2008; Silverman *et al.,* 2008; Chiu *et al.,* 2013). It should be noted that the acronyms CBI and CBT (i.e. Cognitive Behaviour Therapy) appear interchangeably in the literature. CBIs are not a singular approach. Rather they are a '*body*

of methods and strategies used to change behaviour through the active engagement of clients in understanding and taking control of their thoughts, feelings and behaviours' (Mayer and Acker, cited in Mayer *et al.*, 2009:3).

One such programme, which is based on CBI, is the *FRIENDS for Life* programme (*FRIENDS*) (Barrett *et al.*, 2000a). This has a strong international evidence base and has been delivered successfully at a universal level (i.e. to whole class groupings) by educational psychologists (EP) and teachers in RoI and the UK and has been found to be efficacious (Barrett *et al.,* 2006; Stallard 2010;Crosbie, *et al.*,2011*;* Ruttledge *et al.*,2014). The programme has been endorsed by the World Health Organisation (2004:43) as the only anxiety programme *'that appears to be efficacious across the entire spectrum, as a universal prevention programme, as a targeted prevention programme and as a treatment'***.** This programme is supported by NEPS through training teachers nationwide in its implementation.

However, little is known about how EPs can apply CBIs in support of CYP with mild to moderate anxiety in school. Ecclestone and Hayes (2008) propose that a wider debate on the extent to which EPs can adopt more therapeutic roles is needed but few, if any, detailed practice descriptions of EPs work in schools in this area appear to exist. MacKay (2011:12) in pointing to the paucity of extant literature from educational psychology states that *'the subject of health and educational psychology is essentially a greenfield site'* and that '*educational psychology services should position themselves at the centre and not on the periphery of health interventions at school'*. There is a gap in what is known about how to respond to these children's needs at school. Therefore '*more studies are needed that evaluate the effectiveness and efficacy of the delivery of CBTs within 'natural' settings such as school, where the complexities of children's needs can be fully explored.'* (Rait *et al*., 2010:116). EPs are ideally positioned to support children's development (MacKay, 2011). EPs have a broad understanding of factors affecting social and emotional learning (SEL), and are in a position to '*systematically evidence what the most powerful ingredients are for children and young people receiving CBT'* (Rait *et al.*, 2010:117).

Games, puppets, story-telling, calming-imagery and other non-verbal modifications can be used to adapt the '*methods, style and process of the therapy to the children's developmental level*' in order to effect maximum access and benefit of CBT (Stallard 2005:107).Some of

these more creative methods were used in an adapted application of the *FRIENDS for Life* programme for the three anxious children in this study.

Research aims and questions

This thesis explored the perceptions, and professional practice implications for an EP, of a modified intervention for three sub-clinically anxious children in primary school. It sought to:

- develop an understanding of the participants' perceptions (i.e. teachers', parents' and sub-clinically anxious children's perceptions) of the contribution of an adapted CB-based intervention (i.e. *FRIENDS for Life*) to a targeted group (N=3) of sub-clinically anxious children in primary school;
- develop an understanding of what is helpful or unhelpful in relation to reducing the children's anxiety,
- and explore the factors which help or hinder the delivery of a targeted intervention, by an EP, to anxious children in primary school.

The three research questions relevant to execute the aims of the investigation were as follows:

Question 1 Participants' perceptions of the intervention (Aim 1)

1. What elements of the adapted intervention were perceived by the target group children as helpful or unhelpful?

Question 2. Participants' perceptions of mode of response (i.e. verbal or non-verbal) during the intervention (Aim 1)

2.1 What did the target group children perceive to be helpful or unhelpful when the intervention response mode was predominantly non-verbal?

2.2 What did the target group children perceive to be helpful or unhelpful when the intervention response mode was predominantly verbal?

Question 3. Intervention delivery (Aims 2 and 3)

3.1 What factors helped or hindered intervention delivery to the anxious target group children?

3.2 What factors helped or hindered intervention delivery with parents?

3.3 What factors helped or hindered intervention delivery with teachers?

3.4 What factors helped or hindered intervention delivery at a whole-school level?

3.5 What ethical issues arise in relation to intervention delivery at school to children with anxiety?

Research questions 1 and 2 explored the anxious children's perceptions of the *FRIENDS for Life* programme when it was modified to meet their needs. Research question 3 explored the factors which helped or hindered me as an EP in the intervention delivery.

Research context

It is important to state at the outset that all children experience some anxiety. It is a normal part of growing up (Muris *et al.,* 1998). It varies with development stage (Weems and Stickle, 2005) and not all anxious children go on to become anxious adults (Biederman *et al.,* 1990). It is manifest through a combination of children's cognitive, physiological and behavioural responses (Weems and Stickle, 2005). Children begin to think about potential risk (i.e. a cognitive response) and their body prepares for a fight or flight (i.e. physiological response). These physiological responses in children can include butterflies, a racing heart, sweating and dizziness. Their behavioural response involves taking action to reduce risk and stay safe (e.g. anticipating or avoiding future risk by not speaking).

When anxiety persists and significantly interferes with daily adaptive functioning, an anxiety disorder may be diagnosed by a clinical psychologist or psychiatrist outside of school. Children with anxiety disorder have up to twenty nine times the risk of developing depression (Costello *et al*., 2003). At this stage there is a significant negative impact on the child's cognitive development (Cresswell *et al*., 2007), social functioning, family life (Wood and McLeod, 2008) and school performance (Essau, *et al*., 2000). EPs working with NEPS do not diagnose anxiety disorders. They may however refer children, following their parents' consent, to the local Health Service Executive (HSE) clinical psychology services or to the local Child and Adolescent Mental Health Service (CAMHS). This usually follows school-based screening and assessment by the EP.

In the UK, the Department of Education and Skills has introduced major initiatives such as SEAL (Social and Emotional Aspects of Learning) and Targeted Mental Health in Schools (TAMHS). These programmes have been designed to develop the emotional skills which underpin effective learning and positive behaviour. (DCSF, 2008; DFES, 2005).The promoted school based interventions tend to be either universal (i.e. to all children in a class group) or to targeted groups, displaying mild to moderate symptoms, to reduce the risk of symptoms worsening. Few school-based targeted CB interventions for mild to moderately anxious children have been located for the RoI. This proposal aims to fill this gap.

Potential barriers to application of CBIs at school

Society's view of mental health appears to be changing. Weare's (2000) position that mental, emotional and social problems are common to us all, and not just to '*a deviant and/or sad minority',* is helpful in that it provides a basis for the consideration of children with a broad spectrum of social and emotional difficulties ranging from mild and transient difficulties to more severe and persistent difficulties. While this view of everyone's vulnerability seems reasonable, this view is '*far from common'* and there is considerable fear of mental illness which is represented in the associated language and discernible pejorative distancing attitudes towards it (Weare, 2000:99).

> *Within the community there may exist several roadblocks to service provision, including the waiting lists, costs, and need for transportation usually involved in accessing support* (Barrett and Pahl, 2006, cited in Briesch, *et al.*, 2010:156).

In RoI only children with moderate to severe anxiety are seen by *The Child and Adolescent Mental Health Service* (CAMHS) and it is recognised that it can take too long for a family to discover their child needs professional help. The system of support available to families is complex with teachers, health workers and social care workers often working separately to meet a child and family's needs. In the UK regulations were introduced in September 2014 setting out the detailed requirements on local authorities for assessing CYP's education, health and care needs and where necessary drawing up Education, Health and Care plans (EHC) for children with complex needs (Special Educational Needs and Disability Regulations, 2014). Clinic-based intervention '*makes numerous, often class-based assumptions about clients' cognitive, material and motivational resources to engage*

in therapeutic alliance' (Rait *et al.,* 2010). In this regard, a final barrier to support for children with social and emotional learning needs relates to the accessibility of clinic based services for families. Mayo is a county where seventy five per cent of its schools have four or fewer teachers. These schools are widely dispersed and many are rural, and not connected to bus or train routes, making travel to clinic appointments in the larger towns difficult. Thus, the development of school-based responses to anxiety makes sense.

Philosophical underpinnings

Debate in social research is founded on two basic theoretical formulations: the first, epistemology, is concerned with the nature, origins and scope of knowledge; the second: ontology, deals with the nature of social reality (Morrison 2002). In this section I set out my own ontological and epistemological position as well as the type of research that flows from my approach to the process of doing research in an educational context. This includes a discussion of objectivism and subjectivism, voluntarism and determinism, positivism and anti-positivism as well as the relationship between the natural and the social sciences. This will allow me to situate my own research paradigm, which I describe as interpretivist within a framework of symbolic interactionism and social constructivism while, at the same time, allowing me to express my own positionality as an educational researcher interested in the *'new sociology of childhood'* set within a particular case study (Liegghio *et al.,* 2010:88).

When considering what should be regarded as acceptable knowledge, a central issue is whether the social world of children can be studied *'according to the same principles, procedures, and ethos of the natural sciences'* (Bryman, 2008:13). Natural science views the social world as the external medium within which people operate (Rogers, 2003). Within its positivist tradition only phenomena, confirmed by the senses (i.e. phenomenalism), can genuinely be called knowledge. This knowledge is based on facts which lead to laws (i.e. inductivism) derived from value-free investigation (i.e. objectivism) (Bryman, 2008). This objectivist research approach claims to find truth in findings that can be generalised (Morrison, 2002). This positivistic philosophical basis in realism holds that the world exists as an external reality and is knowable to an unbiased observer.

It is important to state at the outset that I reject the existence of a single unidimensional world and the notion that knowledge is hard, objective and tangible. I hold that knowledge

is based upon perspective and on the '*dialectic relations among respondents and the researcher'* (Lomborg and Kirevold, 2003:194). I believe that knowledge is personal, subjective and unique and requires me to become involved with my subjects as a researcher in order to '*grasp the subjective meaning of social action'* (Bryman, 2008:16). In this regard my approach required a logic which sets out to understand children's interpretations of the world around them which reflects their distinctiveness as humans. As such the theory that emerged is based on sets of participant meanings which yielded insights into their perceptions. Rather than a normative, universal explanation, which is the product of a positivistic approach, what emerged were *'multifaceted images of human behaviour*' (Cohen *et al.,* 2011:18).

My ontological position rejects the argument that reality is external to the individual and that phenomena confront us as external facts. Rather, I hold that reality is a product of '*individual cognition'* and created by one's own mind Cohen *et al*., (2011:4). Further, my ontological stance asserts that social phenomena and their meaning are continually being accomplished by social actors. Knowledge as such is indeterminate. A positivist stance would have been irreconcilable with the '*complexity of the human nature and elusive intangible quality'* of anxious children in this study which '*contrasts strikingly with the order and regularity of the natural world'* Cohen *et al.,* (2011:7). Additionally, I reject deterministic views of human agency. I hold with voluntarism and that people are initiators of their own actions with free will and creativity (Burrell and Morgan 2009).

From the interpretive approach adopted, I interpreted participants' meanings and they interpreted mine. The approach aligns with Mead's (1934) symbolic interactionism and the theory of social constructionism (Burr, 2003), which hold that human beings continuously act towards things on the basis of the meaning they have for them. Meaning is embedded in social processes where individuals may align their actions with those of others while constructing their actions according to social contexts in the dynamic activities that take place between people. Thus, like Vygotsky (1962), knowing and learning are viewed as embedded in social contexts, interaction, a sharing of viewpoints and interpretive understandings. '*This type of theory assumes emergent, multiple realities; indeterminacy; facts and values as inextricably linked; truth as provisional; social life as processual'* (Charmaz, 2014:231).

This research is best located under what Christensen and Prout (cited in Greene and Hogan, 2010:42) term the '*new social studies'* of childhood which accords children conceptual autonomy and respects the ways in which they make meaning through their interactions with other children and with adults. Looking at children in this way as social actors means that they should not be passive within the research process. While they may be both '*restricted or encapsulated by social structures'* of school and society, they are also '*persons acting within or towards the structure'* (Christensen and Prout, cited in Greene and Hogan, 2010:50). In this regard this research aimed to respect children's autonomy within the *'new sociology of childhood'* where knowledge and its creations are viewed as interconnected and based on the values, beliefs and assumptions of social constructionism (Liegghio *et al.*, 2010:88).

Linking research philosophy with methodology

The assumptions identified above have direct implications for my methodological approach to this research. My principle concern was on how individuals '*create, modify and interpret the world in which they find themselves'* (Cohen *et al.*, 2011:7). In working with anxious children it was important to enter the field with minimal preconceived ideas about their interpretation of the social context of the intervention in order to optimise my chances of alignment with their needs. My interpretation during intervention sessions of the children's responses was through a process of systematic and frequent constant comparison of the data emerging in sessions which was needed to guide my actions in subsequent sessions. A constructivist grounded theory (CTG) approach to data collection and analysis was selected where knowledge was built from emergent data through a process of inductive theoretical analysis where the study's categories were directly grounded in the data (Charmaz, 2014). In line with GT, leads that emerged during the researcher's interaction with the children were followed (e.g. children's preferred way of learning content and skills). These leads allowed the researcher's background assumptions and disciplinary perspectives to alert him to '*look for possibilities and processes'*(Charmaz, 2006:16) in the emerging data and to function as an instrument of data collection in the development of a deep understanding of a single issue.

'*Qualitative research of all sorts relies on those who conduct it'* and '*we are not passive receptacles into which data are poured'* (Charmaz, 2014:27). My position is aligned with

other social constructivists (e.g. Vygotsky, 1962) who emphasise '*the influence of context, interaction, sharing viewpoints and interpretive understandings'* (Charmaz, 2014:14). The paradigm also holds that social phenomena *'...are not only produced through social interaction but that they are in a constant state of revision'* (Bryman, 2008:19). The paradigm does not claim universal truths but accepts the notion of subjectivity and the personal.

Flexibility to adjust my intervention approach with the children, which is possible with CGT, was particularly necessary in this research as these children, by definition, are at increased risk of panic and/or distress. Alderson and Morrow (2011) point out that a simple question, intrusion or deception may seem slight to the researcher but serious to the child concerned. This flexibility to adjust, which was also grounded in the study's research ethics, addressed later in this thesis, was crucial in the attempt to optimise the anxious children's emotional comfort and engagement with the intervention. Flexibility to adjust data-gathering methods is a strength of constructivist grounded theory, which suited this research. Additionally, grounded theorists *'do not force preconceived ideas and theories on the data'* (Charmaz, 2014:32) but follow leads that are defined in the data or design an alternative way of collecting data in relation to the initial interest

A participatory action research (PAR) (Kemmis and McTaggart, 2005, cited in Denzin and Lincoln, 2005) and constructivist grounded theory (CGT) approach (Charmaz, 2014) was used to guide my actions with the children. This approach, which was practical and collaborative (c.f. Figure 3.1), allowed me to enter the participants' worlds for short periods during intervention sessions in an effort to construct theory which can '*contribute to a speciality field* (i.e. anxiety in children) *and simultaneously extend general theoretical interpretations that cut across fields'* (Charmaz, 2006:153). Within the PAR/CTG framework used, knowledge is viewed as produced through the meaningful participation within a democratic intervention space with the vulnerable children.

A case study was selected to provide *'a unique example of real people in real situations'* that can *'penetrate situations in ways that are not susceptible to numerical analysis'* (Cohen *et al*., 2011:289). This approach was used (i.e. three children in a mixed rural school) as it '*lends itself to the study of processes and relationships* (i.e. in relation to anxiety) *within a setting'* (Denscombe 2010:55; Yin, 1994). Additionally it added to the coherence between

the epistemological and ontological positions adopted which emphasise the uniqueness of the individual and the consequent interpretivist, qualitative research strategy.

The case study arose naturally in the context of my educational psychology service to a school. The school is a typical mixed, rural small school (i.e. less than one hundred pupils) in County Mayo in RoI. Schools of this type represent seventy five per cent of schools in the county. I had a pre-existing relationship with the school which facilitated access for this research. This posed a challenge for me in that my prolonged involvement in the intervention (i.e. over two full school terms) would exclusively consume all of my service time for this school, when other school case work might also need my attention. This required advance negotiation and agreement with the school principal. Crucially though, I was in a position to gain depth of understanding within a natural and safe setting which was important for the anxious children.

Positionality

I was a participant researcher with an insider perspective as the school's EP. It is important therefore that I make clear to the reader my positionality in relation to what is being researched, as '*all writing is "positioned" and within a stance'* (Creswell, 2007:179). I was conscious of the influence my values and beliefs had on the emergent data which emerged. I am aware that the data may be open to alternative interpretation and cautious that the findings presented are not just chosen to suit my own research narrative. '*As researchers, the meanings we attach to things that happen and the language we use to describe them are the product of our own culture, social background and personal experiences'* (Denscombe, 2010:86). Critical comment based on my reflections in regard to my involvement in the research is provided in chapters 4 and 5. All the materials from the research process have been retained for verification should the need arise. A brief professional biography is provided now in order for the reader to grasp how my values and prior experiences may have a '*bearing on the nature of the study'* (Denscombe, 2010:87).

I am a male psychologist in my mid-fifties, who is married with five children. Having completed a Bachelor of Education degree in my early twenties I taught primary-school children between four and twelve years of age in a mixed, suburban primary school for twelve years. I then held a post for five years as a school principal of a similar sized rural

primary school. During that time as a school leader, I maintained a strong interest in providing additional support to learners who needed it. I regularly encountered children who were anxious, slow to settle in school and who frequently presented with psycho-somatic symptoms at school. Solution-focused discussions with their parents gave me some initial insight into what might be helpful for their wellbeing and my professional actions were, I hope, supportive.

After five years as a school principal, I left teaching and completed a master's degree in educational and developmental psychology. I subsequently began work as an EP with NEPS, where I work to this day. This is a nationwide, school-based service whose aim is to support the personal, social and educational development of all children. I frequently work with children, parents and teachers in solution-focused discussions at school. My actions, as an EP, need to empower not just parents and teachers but children also to set reasonable goals for themselves in a broad range of matters affecting their progress in school and life generally. I believe I have strong ability to establish a relaxed rapport, in often difficult and challenging circumstances, with parties.

I am also the senior psychologist within County Mayo and as such lead a team of four other local psychologists. I believe in the new sociology of childhood and in giving children opportunities to influence their future as '*persons acting within or towards the structure'* (Greene and Hogan, 2010:50). I have continued to up-skill in my professional field through continuous professional development. This is my professional duty as a member of the Psychological Society of Ireland and the Health Care Professional Council (HCPC) in the UK.

As an EP I am acutely aware of the link between anxiety and depression in Ireland. The daunting statistics in this aspect of wellbeing in County Mayo are stark. Of the total population of 130,638 people in the county, seven point three per cent (i.e. 9,543 people) were prescribed anti-anxiety/depressant drugs in 2012 (Health Research Board National Psychiatric In-patient Reporting System, 2015).Therefore, I am deeply aware of the need for schools, society and individuals to respond to anxiety's disabling impact.

My belief is that part of the solution to this problem lies in the early introduction of coping strategies to children, parents and schools. Therefore, in 2013, I undertook specific training with NEPS in the *FRIENDS for Life* programme which *'assists children and youth in developing life skills to effectively cope with difficult and /or anxiety provoking situations'*

(Barrett, 2010:5). As mentioned earlier, this programme has a strong evidence base. Since 2014, and in line with NEPS and DES policy direction, I have trained teachers to implement the programme having been accredited to do so. This training, my previous teaching experience, and work as an EP were crucial for this research.

Conclusion

The rationale, aims and research questions for this study were presented in this introductory chapter. The importance of this study is founded in the high prevalence, generally, of youth and adult mental health difficulties in RoI and in the paucity of school-based interventions specifically for those children presenting with an 'at risk' profile for anxiety. There is a gap also in relation to specific practice guidelines for school-based intervention by EPs. My professional background and positionality as an insider researcher were described with a view adopting a reflexive approach which can help to make my potential biases, values and assumptions more transparent to the reader (Creswell, 2007).

Chapter 2 presents an analysis of the literature on which this study is based. It conceptualises anxiety as multi-factorial, critiques some of the difficulties associated with defining sub-clinical anxiety, examines the emerging intervention practices in schools and the associated challenges for EPs. Chapter 3 outlines the approach used to sampling and the use of the PAR/CGT research model to guide my actions, collect and analyse data. It describes for the reader some of the study's care and safety considerations and my attempt to position children within a new sociology of childhood paradigm. The role of the learning support teacher (LST), in observing the intervention, is also briefly described.

The findings from the intervention work are then reported in Chapter 4 with some discussion about the key concepts which emerged. Discussion in Chapter 5 provides a critique of the study's findings. Critical-reflection on my own practice is also included. The final chapter, Chapter 6, synthesises the findings and proposes a new conceptual model which, I propose, can be used by EPs providing targeted support for anxious children within their local primary schools. The document concludes with some recommendations in relation to supporting anxious children. A reflexive account of the professional journey towards a doctorate degree in education which includes an evaluation of the use of the PAR/CTG model completes the thesis document.

Chapter 2 Literature Review

Introduction

This literature review is structured around four broad areas which underpin this participatory action research with sub-clinically anxious children in a primary school. In Section 1, children's anxiety, as a social, emotional and behavioural difficulty (SEBD) and special educational need, is defined and located within a broader context of children's health and wellbeing. The legislative context within which schools respond to anxious children's needs is briefly discussed. How anxiety has been conceptualised and the difficulties with defining subclinical anxiety will be discussed in Section 2. The next section outlines an emerging trend in the literature showing the broad international support for school-based intervention and describes a particular cognitive behaviour approach (i.e. *FRIENDS for Life*) which has gained support within schools in RoI. Finally, debates from the literature in relation to the role of educational psychologists in applying support to anxious children within their various models of service will be critically examined.

A keyword-focused search was carried out using standard databases (ERIC, Academic Search Premier, Medline, Teacher Reference Centre, and Ingentia) in order to identify literature relating to anxiety in schools and the practice of educational psychology. The review centred generally on the last twenty years of published research as this is the period within which schools' role in mental health promotion has come to the fore (Wolff, 1993). The keywords used in this search were anxiety, childhood anxiety, special education needs (SEN), anxiety disorder, sub-clinical anxiety, inclusion, educational psychology, cognitive behaviour therapy and Friends for life.

Research context

Anxiety has traditionally been viewed as a mental health problem. While mental health difficulties may be common, it has been argued that '*mental health is too complex to define simply'* (Weare, 2000:12). Weare argues that any understanding of it depends on our values, preconceptions and assumptions for example about '*the nature of health and illness, the nature of society, the place of the individual within society, what constitutes normality, desirable behaviour and attitudes and so on'* (Weare, 2000:13). In rejecting approaches

which attempt to draw lines between health and illness, it is argued that it is '*preferable to conceptualise health and illness on a continuum given that the majority of people, including those who feel well move positions on this continuum at various times during their lives'* (Weare, 2000:18).This view that mental health difficulties, like anxiety, affect not just *'a deviant and/or sad minority'*(Weare, 2000:19) seems reasonable and aligns with the continuum approach evident in DES/NEPS policy of support for children with SEBD in the RoI. In my fifteen years of experience as a school psychologist it is apparent to me that there are a number of children in each school who behave in a way that suggests underlying anxiety. Teachers include them without drawing attention to their difficulties but few strategic interventions are ever implemented to meet their needs.

In recent years, positive mental health is viewed as part of children's overall health, with distinctions between one's physical and mental health being made less frequently. Within this study positive mental health will be defined as *'a state of emotional and social wellbeing in which the individual realises his or her own abilities, can manage the normal stresses of life, can work effectively, and can play a role in his or her community* (World Health Organisation, 2001).The management of the normal stresses of life, frequently described as resilience, is understood as the ability to overcome developmental hazards and positively adapt to regain mental health despite experiencing adversity (Herman, *et al.*, 2011).

Wellbeing is defined as a holistic subjective state which is present when a range of subjective feelings, among them energy, confidence, openness, enjoyment, happiness, calm and caring are combined and balanced (Prever, 2006). Morgan and Ziglio (2007) argue that wellbeing should be viewed as an umbrella term until research incorporates children's experiences from their viewpoint and places greater emphasis on their assets rather than on their deficiencies. Others recommend that service providers use the terms emotional and social wellbeing, and emotional and social competence, which focus on teaching and learning of knowledge, attitude and skill (Weare and Gray, 2003). Social and Personal Health Education curricula (NCCA, 1999)for example state that the child should be enabled to recognise causes of personal worry and identify appropriate coping strategies. Overall, this literature review reveals that 'wellbeing' is a relatively recent term in the broader mental health arena.

The literature also reveals a discourse in relation to health promotion and wellbeing in contexts wider than just the individual. The importance of health promotion within the wider

school environment beyond the individual in the classroom, for example, underpins comment about the link between ecology and health promotion (e.g. Richard *et al.,* 2011). Approaches emphasising the importance of the setting for health promotion activity originated from the Ottawa Charter for Health Promotion which acknowledged the importance of people-environment interactions (WHO, 1986). More recent developments identify the health and wellbeing of the people as being influenced by connectedness and relationships between the intrapersonal, interpersonal, organisational and communal system which operates with a locality (e.g. Green and Kreuter, 1990; Stokols, 1992, Dooris, 2009). If one accepts this wider approach, then programmes and interventions should be directed towards modifying the environment in which a person functions, rather than on changing the individuals themselves as has been stated in the World Health Report (2002)

... since individuals are not free agents, risks can best be understood as a social construct within particular historical and cultural contexts and within groups and institutions, not only at the individual level ... risks should not be treated independently and separately from the complex social, cultural, economic and political circumstances in which people experience them" (WHO, 2002, p. 36-37

A critical question arises though, as to whether health-promoting effort should apply to a broad 'settings approach' (e.g. developing a positive whole school ethos), as opposed to programme-based approaches, which develop skill in individuals. Noblet and Murphy (1995) argue that the settings approach does not reduce the relevance of the individual and programme-based conventional methods, but draws attention to the importance of dealing with the underlying factors which might obstruct people's wellbeing within a particular setting. Of interest for this study is that some difficulties with raising awareness across whole school communities with regard to the benefits of established, health-promoting programmes (e.g. Zippy's Friends) have been identified. Teachers, for example, have indicated the need for training for all staff, so that the broad effects of programme strategies can be reinforced in all classrooms through cross-curricular activities and within the school playground. They have also pointed out that greater parental involvement is required so that what is taught in class can be reinforced in the home environment and in local community settings (Clarke and Barry, 2010). A key question arises, also, as to whether teachers and schools view themselves as holding some responsibility for raising this awareness about the benefits of wellbeing programmes within broader school settings. I hold that programme-based approaches (e.g. Zippy's Friends, Friends for Life), and the settings approach (e.g.

Health Promoting Schools), are mutually complimentary, and that a positive approach by an individual to their own wellbeing at school, can give rise to benefits for all within the wider school environment.

The predominance of the psycho-medical model

In a review of international trends for the OECD in relation to students with SEN three models, or paradigms, which posit certain relationships between individuals with disabilities were identified (Mitchell, 2010): The psycho-medical paradigm which is based on an assumption that deficits are located within individual students; the socio-political paradigm, which focuses on structural inequalities and the organisational paradigm in which special education is viewed as a consequence of inadequacies within mainstream schools. It found that most countries have a mix of paradigms but also that the psycho-medical model remains dominant even though other models which emphasise the importance of the environment have gained some support.

The examined literature is replete with descriptors from psychiatry or medical disciplines which have dominated the discussion. Articles in medical journals refer to disorder, epidemiology, etiology, diagnosis, while university and other educational publications refer to behaviour, prevalence, cause, assessment and identification. This contrast in terminology serves to highlight a disability versus special educational needs approach to anxiety. There is a lack of reference in official SEN documentation in schools to anxiety and how to respond to it. This review found that the language associated with anxiety very much reflects its clinical/medical research base which tends to pathologise differences and unnecessarily promotes *'...vocabularies of pathologisation'* (Tait, 2001:10). I believe that more school-based research which can inform school-related responses is needed to redress this imbalance.

Little has been written about the presentation or management of anxiety in primary schools in RoI. This represents a major gap and is in itself a reason for further research. The most recent DES/NEPS practice guidance issued to all primary schools refers to behavioural, emotional, social, difficulties (BESD) generally and not to specific types of behavioural difficulties. Anxiety, within these guidelines, falls under the general term BESD and is understood to exist on a continuum from mild and transient to more severe and/or persistent. NEPS' policy statements acknowledge that behavioural, social and emotional, difficulties can be internalizing and/or externalizing behaviours which act as a '*barrier to their personal,*

social, cognitive and emotional development', (NEPS 2011:4). This position seems appreciative of the broad impact of anxiety across many developmental domains.

The Legislative Context

Ireland is an island with over 4.5 million people situated in north-western Europe. Education is compulsory from the age of 6 to 16 years (or until students have completed three years of second-level education). Children attend primary school for eight years and under the Irish Constitution children have the right to a free education (Article 42, Bunreacht na hÉireann). They usually start at age five (the minimum age is four by September 1st of the school year). Approximately 500,000 children attend the state's 3,165 ordinary primary schools (hereinafter termed 'primary schools'). Half of these schools have less than four teachers and most accommodate all primary-aged pupils. This particular study takes places in a four-teacher primary school situated in a rural area in County Mayo. The school is allocated an additional part-time learning-support teacher (LST) who visits twice weekly.

Legislation passed during the last fifteen years in the RoI has revitalised the primary school sector of the Department of Education and Skills (DES) (e.g. The Education Act (1998); The National Disabilities Authority Act (1999); The Children's Act (2001); Education for Persons with Special Educational Needs Act (EPSEN), 2004). This legislation provides definitions, outlines teaching roles and promotes the inclusion of pupils with severe emotional disturbances like anxiety in mainstream schools. In the RoI, the Department of Education and Skills (DES) categorises anxiety as a social and emotional behavioural difficulty (SEBD) and as a special educational need (SEN) because of *'a restriction in the capacity of a person to participate in and benefit from education'* on account of an enduring mental health disability (Education for Persons with Special Educational Needs Act (EPSEN), 2004:6). RoI policy aligns with international trends in special education which are moving radically from a disability model, which viewed the specific learning deficits as within the individual, to a 'social model' of disability which prioritises inclusion (EPSEN, 2004).This approach puts the focus on supports and interventions rather than on labels and definitions (Llewellyn and Hogan, 2000).The Affirmative model (e.g. Swain and French, 2000) has also been proposed as a counter to models which focus on personal tragedy or loss narratives. It is expressed in the voices of deaf people, for example, who might say: "*Deafness is normal for me. I wouldn't want to be other than deaf"*. The model draws on the perspectives within the disabled people's movement .I believe that in

expecting children to give voice to their anxiety there is arguably a challenge to the relevance of this model for them.

Treatment programs placed in schools circumvent many of the barriers that are often associated with children accessing off-campus services (Liddle and Macmillan, 2010). In the RoI there have also been positive developments in this regard. Recent collaboration between Health and Education sectors for example resulted in the publication of *Wellbeing in Primary Schools: Guidelines for Mental Health Promotion* (Department of Education and Skills, Department of Health and Health Service Executive, 2015). The guidelines emphasise the important role school plays in mental health promotion and state that the most effective interventions in schools involve one or more of the following approaches: a social competence approach where the skills of self-management and problem-solving are learned, a whole-school approach, continuous implementation approaches, a focus on wellbeing rather than on mental illness and the provision of social support to young people. These guidelines are welcome.

Department of Education and Skills policy states that school should support the small number of young people '*who are at risk of developing unhealthy patterns of behaviour or those who are already showing signs of mental health difficulties'.*(*Wellbeing in Primary Schools: Guidelines for Mental Health Promotion,* DES, 2014:23)The guidelines indicate the suitability of small groups to address their specific issues and state that the effectiveness of the interventions can best be monitored within a continuous cycle of plan, implement and review.

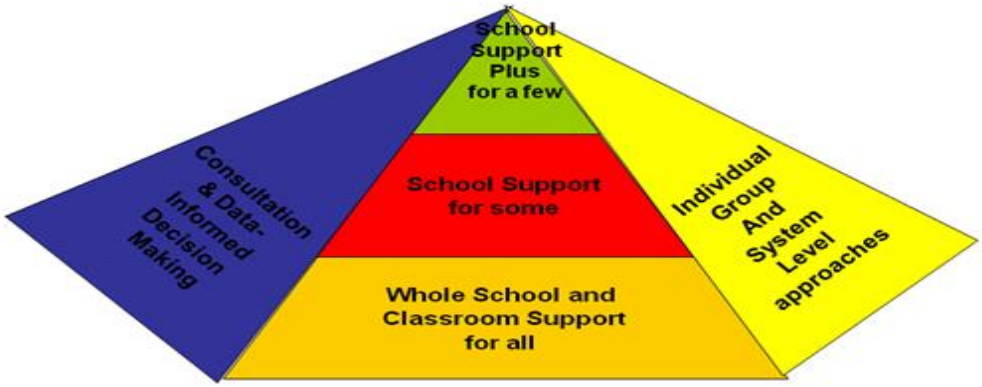
The role of the National Educational Psychological Service (NEPS)

Anxious children are more likely to experience lower self-worth, difficulties adjusting to school, peer rejection, social isolation, increased teacher attention, academic difficulties and school refusal (Coplan, *et al.,* 2001). Longitudinal research indicates later manifestation as loneliness, depression and early school leaving (Gest, 1997; Van Amerigen *et al*., 2003). For these reasons, anxious children, with and without a formal diagnosis by a health professionals (e.g. a clinical psychologist), are frequently referred to school psychologists in NEPS. Within the National Educational Psychological Service (NEPS), where I work, the work focuses on pupils' educational needs, rather than on their disability. The NEPS framework for practice, or model of service, as seen in Figure 2.1, guides EPs to use

'*evidence-based practices and programmes to improve academic and social-emotional outcomes for all learners'* regardless of whether the concern relates to direct or indirect work with individuals, groups or at a whole-school level issue (NEPS, 2013).The approach which values data-informed decision making is both an ethical and professional practice principle which must guide an EP's work.

> *to support the personal, social and educational development of all children through the application of psychological theory and practice in education, having particular regard for children with special educational needs* (NEPS Mission Statement).

Figure 2. 1 NEPS framework for Practice



The NEPS policy guides EPs to draw on multi-modal approaches to intervention based on multiple theoretical perspectives as required (i.e. biological, psychodynamic, behavioural, cognitive, social learning, humanistic, eco-systemic, and ecological) (NEPS, 2011). Recent professional training for the NEPS' psychologists in interventions based on *The Incredible Years* (Webster-Stratton, 2011) and *Friends for Life*, guide psychologists to consider both within-child and external factors including the role of teachers and parents. In practice, psychologists draw on these perspectives differentially according to their training and professionally judge what might be helpful within the casework context, without the need to determine whether the level of anxiety meets any established criteria for a subclinical or clinical diagnosis of anxiety. This flexibility in the deployment of skills is useful, but

arguably, also highlights the need for an evidence-base to inform decision-making, given the associated risks when working with anxious children.

Two key inter-related conceptual models inform the EPs and NEPS' model of service to schools. Firstly, there is Ecological Systems Theory as developed by Bronfenbrenner (1979) which describes human behaviour as a function of complex interactions between the characteristics of individuals and the environments in which they function. This theory rejects medical models which focus on '*context-independent disease states'* and firmly recognises that 'context counts' (Gutkin, 2009:478). The second model, Prevention Science, acknowledges the importance of environmental factors and is concerned with the identification of potential risk and protective factors to prevent or reduce the impact of human dysfunction (Coie *et al.,* 1993). In alignment with the NEPS' model of service is empirical evidence supporting multiple influences on childhood anxiety including parent psychopathology, temperament, parenting practices, family environment and community factors (Vasey and Dadds, 2001). Given that anxiety is conceptualised as multi-factorial, the NEPS framework supports a psychologist/researcher's exploration of the interaction between '*internal states and external environments'* (Gutkin, 2009: 478). As can be seen in Figure 2.1, *'The NEPS Framework for Practice'* psychologists use a three-staged approach to intervention which is described as a continuum of support. This study's intervention has been carried out at Stage 2 *'School support for some'* and delivered to targeted pupils (i.e. three sub-clinically anxious pupils).

The NEPS policy guidance serves to counter within-child explanations of anxiety which serve to 'pathologise' the condition (e.g. Tait, 2001). It serves also to facilitate a broad consideration of the school and community context within which the child lives and works, and helps to avoid a conceptualisation of the problem predicated on the Individual Medical Deficit (IMD) model of disability with its underlying assumptions of diagnosis, treatment and cure (Giddens, 2006). Thus, from a professional practice point of view, I am mandated to range broadly in the search for solutions for anxious children, which is a relevant task within this proposed study. However, in reality, while the NEPS model of service offers a broad canvas on which to conceptualise and identify anxiety, there are few, if any, examples of school-based, targeted interventions for children with elevated anxiety, directly provided or facilitated by its psychologists, in the service's research repository or through its organised professional training events.

To summarise, it is apparent from the recent literature that anxiety is understood from a broad perspective. The definition of SEN which considers the restriction in the capacity of a person to participate in and benefit from education for anxious children is helpful in creating broadly based responses which have psychological and social components aimed at increasing anxious children's competence and ultimately their participation in life. The conceptualisation of anxiety as being part of normal life is also helpful as is the merging of mental health and physical health under one umbrella domain simply termed, health. These contemporary understandings are relatively positive and served to effect a less fearful engagement with this study's participants.

Conceptualisation of childhood anxiety

Introduction

This section will examine how sub-clinical anxiety in childhood is conceptualised in the literature, its causes and impact on functioning.

The Diagnostic and Statistical Manual (5th Edition) (DSM V) (American Psychiatric Association, 2013) recognises the existence of a number of discrete patterns of anxiety including separation Anxiety Disorder, Panic Disorder, Specific Phobia, Social Anxiety Disorder and Generalised Anxiety Disorder. There is evidence that having an anxiety disorder strongly predicts the chances of having at least one more of the disorders. (Rapee, *et al.,* 2009) which is an argument for discussing all of these various anxieties as one group. Further, these anxieties are manifest in different situations and in the presence of specific stimuli suggesting that elements of the causal factors can be external to the individual. Relying solely on this situational approach would be unhelpful and create an impression that the problem *'is actually tied up in the particular stimulus the individual fears'* (Lebowitz and Omer, 2013:4). A final reason for discussing them as one group lies in the similarity in proven effective treatments across the condition. These treatments/interventions will be discussed in more detail later.

Subclinical anxiety

While a clinically diagnosed anxiety disorder can have a crippling effect on a person's functioning (Coplan, *et al.,* 2001), milder forms and manifestations of anxiety can also be

experienced even in psychologically healthy people (Weeks *et al.*, 2009). These subclinical levels of anxiety can adversely impact cognitive control (e.g. Ansari and Derakahan, 2011) and increase the risk for socio-emotional difficulties (Weeks *et al.*, 2009). The Weeks *et al.*, (2009) study compared non- anxious children with those whose anxiety levels were more than one standard deviation above the mean, on the Social Anxiety Scale for Children-Revised (SASC-R, La Greca, and Stone, 1993). Overall, the literature reveals that even sub-clinical levels of anxiety are widely considered to be a risk factor for the later development of more significant internalising disorders (Banerjee and Henderson, 2001; Morris et al., 2004).

There are difficulties, however, finding a consistent definition of what constitutes subclinical anxiety. Some studies discuss the need to differentiate between 'normal' and 'pathological' anxiety, and conclude that there is much '*definitional ambiguity'* (e.g. Rothi *et al.*, 2008:1224). Definitional difficulties are reflected in the results from epidemiological studies where prevalence varies according to the definition used to define the impairment (Klein and Pine, 2001).

The choice of agreed and appropriate diagnostic thresholds has been regarded as a critical issue in the identification of levels of anxiety. Some have proposed that there is little evidence for natural points of rarity for most disorders, including anxiety (Beesdo *et al.*, 2009). Furthermore, anxiety disorders in children, it is argued, cannot be easily assessed with standard questionnaires or interviews that have been derived from adult instruments. Symptomatic thresholds in relation to the number of symptoms required, intensity, severity and temporal thresholds, such as duration and persistence within a particular time frame of a person's life, are also problematic (Pincus *et al*., 2003). Beesdo *et al.,* (2009) propose that the time point and time frame are crucial to diagnostic decisions by clinicians. They point out, however, that there is considerable fluctuation in specific anxiety disorders which have *'a strong tendency to naturally wax and wane over time',* thereby; impacting accurate prevalence rates (Beesdo *et al.*, 2009:9). Overall, they suggest that stability rates for anxiety disorders among youth are low to moderate at best. Consequently, a lifetime approach is supported in preference to a four-week or twelve-month, cross-sectional approach to identification. However, developmentally more differentiated information is needed to *'clearly facilitate recognition and diagnosis at all ages, particularly in children in whom the border between normal and pathological phenomena may be particularly narrow'* (Beesdo *et al.*, 2009:16).

In the context of this study, a dimensional approach was adopted where the individual children's anxiety levels were judged by teachers and the researcher according to severity along a study-specific, theoretical continuum, without reference to clinical threshold criteria which might prove problematic. This approach aligns with emerging models of intervention and support which emphasise a school's role in assigning resources according to need within the particular school context, and crucially without the need for a formal diagnosis (DES, 2015). Critically, this approach also aligns with Weare's (2000) position which does not necessitate the drawing of lines between health and illness, or a reliance on a psycho-medical model for diagnosis in advance of intervention. However, it seems counter to current legislation (e.g. EPSEN, 2004), which still categorises anxiety for the purposes of resource provision as an enduring health disability. Clearly, emerging dimensional definitions of anxiety, and models of school-response being piloted, need to be reconciled.

Sub-clinical anxiety is regarded in this study as a mild to moderate mental health need. As stated, few definitions of what actually constitutes 'mild or moderate anxiety' have not been found, but one description, being used in New Zealand in the context of The Prime Minister's Youth Mental Health Project (2015:10), I believe has some practical usefulness for this study. It states that mild to moderate mental health needs are

> *issues of emotional stability and behaviour –not serious enough to require a specialist referral, but of concern because they signal that a young person is distressed. There is potential for things to become worse in the long term, if not addressed early.*

Aetiology of anxiety

The aetiology of anxiety is regarded as multi-factorial. Many researchers have focused on biological and genetic causal factors (e.g. Warren, *et al.*, 1999) and shown that children are at greater risk of developing an anxiety disorder if the disorder is present in their parents (Beidel and Turner, 1997). Others have suggested that a shy inhibited temperamental trait that is marked by wariness and discomfort in novel environments is a key component of anxiety in children (Kagan, 1997). The development of social anxiety has also been associated with the childrearing style of parents. Rapee (1997), for example, outlined a link between overcritical and protective parents and anxious children. Finally, social modelling is also regarded as contributory, suggesting that when parents model anxious behaviour (e.g.

view problems as unsolvable), their children may also come to view problems as insurmountable, catastrophic and dangerous (Gerull and Rapee, 2002).

Temperamental and cognitive biases

Viana and Gratz, (2012) propose that a complex interrelationship exists between individuals' temperaments or biologically based individual differences (e.g. differences in behavioural inhibition and anxiety sensitivity) and their cognitive interpretations and judgements of their experiences. They argue for a '*developmental progression from temperamental to cognitive risks culminating in the expression of anxiety symptoms'* (Viana and Gratz, 2012:1122). As temperamental risk factors in the development of anxiety, behavioural inhibition (i.e. the tendency to react cautiously and with restraint to novel stimuli) is thought to be highly heritable (DiLalla *et al.,* 1994) and along with anxiety sensitivity has received significant empirical support (e.g. Taylor *et al.,* 2008). Research suggests an increased sensitivity to physiological cues to anxiety (i.e. anxiety sensitivity), which develops early and has a strong genetic basis (Taylor *et al.,* 2008). Additionally, associations between behavioural inhibition and anxiety have been found in non-clinical individuals (Viana *et al*., 2011) and in individuals who do not meet full criteria for generalised anxiety disorder (Lawrence and Brown, 2009).

Parallel lines of research into cognitive factors have consistently shown that anxious individuals make errors in interpretation of their experience (i.e. cognitive distortions) (Beck, 1976). They misjudge their ability to cope with neutral stimuli (Mathews and McLeod, 2002) and are more likely to interpret ambiguous situations as threatening (Butler and Matthews, 1983). These interpretive and judgement biases are also significantly linked to worry and internalising problems in individuals who are non-clinically anxious (Viana *et al.,* 2011). Viana and Gratz (2012) propose that there is now preliminary evidence for a theoretical model which shows a developmental progression from early temperamental differences (Kagan and Snidman, 2004) to cognitive/interpretative and judgement biases which emerge later (White, *et al.,* 2010) and ultimately culminate in the expression of anxiety symptoms.

Differences between childhood and adult anxiety

There is also emerging comment in the literature that school-aged children's reports on worry may in fact reflect a concept that is qualitatively different from adult worry. Carr and

Szabó, (2015), for example, claim that children aged seven to twelve years associate their experience of worrying more strongly with fear, than with thinking about negative outcomes. However, it is common practice to explain worrying to children in terms of a thinking process, and to differentiate it from fear (Muiris *et al.,* 2000). Carr and Szabó, (2015) also argue, that there are important changes in the nature of worry during late childhood which serve to question previous evidence for the emergence of an adult-like worry process between the ages of seven and eight (Vasey, 1993). Crucially, it appears that frequently employed cognitive behaviour-based interventions for children (e.g. FRIENDS), while modified in content and delivery, are arguably just simplifications of adult approaches based on the work of Beck (1979), for example, and do not adequately reflect any qualitatively different conceptualisation of childhood anxiety.

Findings from a number of studies show that children who report greater feelings of social anxiety even in the absence of a diagnosed clinical anxiety disorder, also tend to experience other socio-emotional difficulties. As well as having difficulties forming relationships (La Greca and Stone, 1993; Bokhorst*et al*., 2001), there is evidence that socially anxious children report disliking school and wanting to avoid school by comparison with children who are not anxious (Murray *et al*., 2009). Additionally, in this study on one hundred and seventy eight children aged between 7-8years, socially anxious children indicated that they would be more likely to use internalising strategies like worry and self-blame when coping with social stress.

It has been demonstrated that children with low working memory and a complimentary cognitive style experience an increased level of instability due to the '*cyclical effect of decreasing working memory capacity and increasing levels of anxiety'* (Grimley, Dahraei and Riding, 2008:220).There appears to be a significant impact of anxiety on speaking behaviours at school. Communication apprehension (CA) has been defined as an internal cognitive state generated by a fear of communicating with others (Monroe *et al.,* 1992). Van Amerigen *et al.,* (2003) have found that anxious people cited fear of speaking in front of class and feeling nervous at school as the two most common reasons for leaving school early and not enjoying school.

Many children with anxiety are reticent speakers (Monroe *et al*., 1992), and research on selective mutism, a condition in which children do not speak or speak in whispers at school, points to anxiety as the most consistent explanation for this non-speaking behaviour at school

(Blacke and Udhe, 1995; Beidel and Turner, 2005). Research also indicates that mutism is more common within the classroom than within the playground (Kumpulainen *et al* 1998) and the condition is slightly more common in girls than boys (Kumpulanein 2002; Standart and le Couteur, 2003).

Prevalence

As well as being a normal part of life, anxiety is also regarded as a mental health difficulty and it is estimated that around 25 per cent of children in the developed world have some form of identifiable mental health problem (Harden, *et al.,* 2001). About 10 per cent meet the criteria for a mental disorder.

Anxiety, in the context of childhood mental health, gives particular cause for concern in Ireland**.** Statistics show that anxiety-related conditions are the second most referred group after those with attention deficit hyperactivity disorder, (ADHD). The Second Annual Child and Adolescent Mental Health Service Report, '*A Vision for Change'* Report (2009-2010) indicates that sixty two per cent of all children referred to its service were aged between five and fourteen years, and that anxiety disorders represented 16.1 per cent of these referrals. The report emphasises that mental health in childhood is a prerequisite for normal growth and development. Most children have good mental health, but studies have shown that 1 in 10 children and adolescents suffer from mental health disorders severe enough to cause impairment' and that *'mental health disorders in childhood are the most powerful predictor of mental health disorders in adulthood'* (CAMHS Report 2013:4).

Further, there is a well-established association between mental health and suicide, and in 2012, the RoI had the sixth lowest overall rate of death by suicide in the EU at 11.8 per 100,000 of population in (National Office of Suicide Prevention, 2012). The data showed however that the comparison is less favourable for younger groups with 13.9 per 100,000 deaths by suicide in the 5-24 year old age bracket or fourth highest of the 27 EU countries. While the highest rate of suicide in Ireland is among 20-24 year old males at 31.9 per 100,000, the group which has experienced the greatest increase from 2001 to 2010 is those females aged 15-19 years which increased from 3.9 to 6.5 per 100,000. The rate of deliberately self-harming young women aged 15-19 for 2012 is striking also with six hundred and seventeen per 100,000. Of concern is that one in every one hundred and sixty two girls in this group presented to hospital in 2012 as a consequence of deliberate self-harm. This is a concern for me as an applied professional who works with anxious children.

The Royal College of Surgeons Report for Ireland (Cannon *et al.,* 2013) also reports that internationally, with a rate of 15.4 per cent, Irish adolescents in the 11-13 age range have higher rates of mental health disorder than similarly-aged adolescents in the USA (11.2 per cent) and the UK (9.6 per cent). Epidemiological studies in Canada show that about 6 per cent of children have anxiety or about 2 to 3 children in every classroom (Waddell *et al.,* 2002). The most prevalent types of disorder identified in the Cannon report for the 11-13 age group was anxiety.

Prevalence rates for sub-clinical anxiety in children have not been located in the literature. One figure for adults indicates that 17% of the UK population experiences sub-threshold common mental problems such as anxiety and depression, with the majority dealing with them without intervention (McManus *et al.,* 2007). These mild to moderate difficulties can be regular occurrences, vary in frequency and severity and according to strengths, vulnerabilities and life circumstances.

Teachers of anxious children

Teachers have been found to use their experience of normative behaviour, intuition and/or notions of common sense rather than any clinical criteria, to identify students who may exhibit mental health difficulties (Rothi *et al.,* 2008).Viana *et al.,* (2008) suggest that it is the children who are disruptive who are noticed more by teachers and school personnel. Quiet and anxious children are not seen as a bother unlike children with conduct disorder for example. Overall, the evidence that teachers can accurately identify anxious children appears mixed. Layne *et al.,* (2006) found that children rated as more anxious by their teachers had indeed higher levels of anxiety as compared to children not rated as anxious. In contrast Rimm-Kaufman and Kagan (2005) argue that teachers are less accurate at identifying internalising behaviour in early childhood. Teachers, it has been suggested, may not be aware of subtle nuances of children's peer relations as many important interactions take place in the school yard, and children are frequently too embarrassed to expose their anxiety to teachers (Pina *et al.,* 2001).

Murray *et al.,* (2009) also found differences between teacher ratings and self-report in relation to the socio-emotional adjustment of socially anxious children and posit two possible reasons for the apparent incongruity between teacher ratings and self-reports of socio-emotional adjustment. Firstly, teachers may be unable to detect the often subtle

difficulties and the children themselves may not want the teachers to know about their negative experiences, perhaps because they feel embarrassed or shamed. Secondly, the anxious children may be exhibiting cognitive distortions. Eysenck (1999) has shown that individuals diagnosed with anxiety disorder tend to exaggerate the severity of their ineptitude.

Parents of anxious children

Parental cognitions may contribute to the intergenerational transmission of anxiety (Wheatcroft and Creswell, 2007). This study suggests that parents' perceived control over their children's behaviour may reflect the parents' own anxiety rather than their child's anxiety. Further, parents of anxious children expect their children to be more avoidant (Barrett, *et al*. 1996), more anxious (Kortlander *et al.,* 1997) and to cope less well in comparison with parents of non-anxious children. This evidence, it is argued, offers a strong basis for interventions that aim to change parents' cognitions and behaviour in relation to anxiety (Wheatcroft and Creswell, 2007).

Lebowitz and Omer (2013) have developed the *Supportive Parenting for Anxious Childhood Emotions* (SPACE) programme and have outlined some of the home-based difficulties which might make children reluctant to co-operate with treatment. They suggest that anxious children show little hope that their own efforts will pay off and fear that the treatment will not help. Secondly, and unsurprisingly, there is the fear of the treatment itself and what it might entail (e.g. exposure to new and frightening demands). Thirdly, because of their '*prolonged behaviour inhibition and on-going stress',* depression had developed and led to a sense of helplessness (Lebowitz and Omer, 2013:153). Additionally, they argue that within their homes there is frequently in place some '*...system of avoidance that allows the child to avoid any situation that would provoke the anxiety*' and the child-parent relationship is *'...so embattled'* that the child will not co-operate with a request that is perceived to be of interest to the parent (Lebowitz and Omer; 2013:153).

School-delivered programmes invariably recruit parents to reinforce programme delivery at home. The literature however reveals some evidence that the relationship of parents of anxious children with teachers can be '*quite unusual'* making this co-operation more difficult (Kumpulainen *et al.,* 1998:28). This is understandable given the higher levels of anxiety and other psychiatric conditions among parents of anxious children (Beidel and Turner, 1997; Remschmidt *et al.,* 2001). Also, they may have difficulty fully grasping the

impact of the anxiety on their child's social and academic progress believing that it is only shyness which they will '*grow out of"* in time (Kearney, 2010:13).

The teacher-parent-psychologist relationship is a valuable resource in relation to the education of parents in decision-making relating to interventions for this population (Carlson *et al.,* 2008: 368). In this EP's experience these relationships with teachers and parents are indeed valuable and can be developed due to NEPS policy of assigning its EPs to specific schools for a number of years. This resonates also with information provided to parents when a school refers a child to NEPS which states that '*We* (i.e. NEPS) *will also discuss with you things that you do at home to help your child'* (NEPS, 2014:12).

Identification of anxious children at school

Carr (1999) draws a distinction between phobic anxiety and generalised anxiety. The former arises as a reaction to stimuli confined to clearly defined class of objects events or situations. With generalised anxiety the eliciting stimuli are less circumscribed, with many non-threatening events being interpreted as potentially threatening and the person experiencing an on-going level of anxiety. These two kinds of anxiety have been described as state (i.e. phobic anxiety) and trait anxiety (i.e. more enduring). If one agrees with these typologies, then a critical key issue arises for teachers and professionals in terms of whether coping strategies should have a context-specific relevance (i.e. how to overcome my fear of water), or whether strategies need to have broader applicability for generalised anxiety. It can also be argued that these distinctions are irrelevant within schools, and that a focus on adaptation and coping, even with mild anxiety, should remain the key objective for children.

When discomfort, due to anxiety, impacts the completion of developmentally appropriate tasks such as socialising with friends and going to school, children may be referred to clinical services (Carr, 1999). Making a decision to refer is arguably difficult, though, as each child has his own *'unique constellation of affective and somatic experiences that underpin discomfort'* (Carr, 1999:440). Crucially, the DES policy advises that *'in the event of a child presenting with mental health concerns, which are above and beyond the capacity of the school to provide adequate support'*, the school should follow its existing referral protocols to external services or a GP (DES, 2015:21). Little guidance is available to EPs or teachers, however, in relation to what might represent mild and/or unacceptably high levels of anxiety. It could be argued that because of the subjectivity of the anxiety experience, it is not possible

to develop a reliable set of threshold criteria to aid differential decision-making in this regard.

In relation to the identification and classification of human disorders, researchers and clinicians have long recognised the benefits of dimensional assessment (LeBeau *et al.,* 2012). In this regard, the recent fifth edition of the Diagnostic and Statistical Manual (DSM-5) features a new lifespan approach to mental health. The approach emphasises how various anxiety conditions manifest at different stages of life. The dimensional approach to assessment and classification of psychopathology, it is argued, allows clinicians and researchers to gauge the severity of a disorder and to consider subclinical presentations and changes over time by repeated assessment (Le Beau *et al*., 2012). Further, a valuable aspect of dimensional assessment is that it can facilitate the '*capturing of more substantive heterogeneity'* in regard to symptoms that are associated with multiple diagnoses and clarify diagnostic co-morbidity (Kraemer, 2007).

While it is argued that clinical interview is the preferred way to identify children who are anxious, Weissman *et al.,* (2009) highlight the difficulties in using this method in school settings. The reliable use of interview schedules like the Anxiety Disorders Interview Schedule (ADIS) (Silverman and Albano, 1997) is time-consuming, costly, difficult to transport for use in schools. Administration requires the training of interviewers to ensure reliability. Secondly, clinical interviews focus on a range of clinical symptomatology and can fail to focus on the information most relevant to school personnel in relation to school attendance, achievement and social functioning.

Studies have shown that due to their covert nature, children with internalising behaviours present unique challenges in referral, assessment and intervention. This, in part at least, is because schools typically depend on reactive methods when identifying students in need of behavioural support (Walker *et al.,* 2005). They are identified and referred less than peers who are acting out (i.e. externalising behaviours) (Kauffman, 2001). This may also explain why the focus on work with anxious children has been mainly on assessment and classification rather than on intervention (Merrell, 2001).

There is concern that medical personnel often fail to diagnose or refer for further treatment young children who are silent and anxious (Schwartz *et al.,* 2006).Childhood anxiety disorders, although very prevalent, are the least often treated psychiatric condition (Chavira

et al., 2004). In the diagnosis of an anxiety disorder, it is widely acknowledged, that multiple informants should be used when assessing children's psychopathology (Essau and Barrett, 2001). There is a need, however, for caution in assessment as the reliability of parents and teachers as informants of internalising behaviour has been questioned (Green *et al.,* 1990). Teachers have rated socially anxious children as less academically skilled than non-anxious children. Murray *et al*., (2009:970) point out that this may be because of a '*pre-existing schema of how a good student should behave'*. In other words a good student is mentally categorised as one who clearly expresses opinions, is not afraid to take risks in class and makes strong positive connections with others. This is supported by Hughes *et al.*,(2009) who reported that teachers rated shy students described in hypothetical vignettes as being less intelligent, having poorer academic skills and having learning difficulties than more talkative children they were compared with.

Support for the use of self-report of anxiety by the children themselves has grown nevertheless on the basis that anxiety is an '*internally derived experience'* (Essau*et al.*, 2011:26). The Spence Children's Anxiety Scale, (SCAS) (Spence, 1998) for example (c.f. Appendices 19 and 21) is an instrument which can easily be administered by a teacher with a whole class. This is a widely-used self-report questionnaire to assess children's perception of the frequency with which they experience anxiety. It is widely used in Irish schools by EPs and its psychometric properties (i.e. internal consistency and validity) have been found to be '*excellent*' (Essau *et al*., 2011:19).The SCAS (c.f. Appendix 21) is a widely used scale within the NEPS service. It comprises forth four items, thirty eight pertaining to specific kinds of anxiety with six 'filler' questions to reduce the potential for negative response bias. Responses to statements about anxiety are indicated on a scale ranging from 0 (never) to 4 (always). The responses are summed to an overall score, with higher scores indicating anxiety.

Given that anxiety impacts adaptive behaviour EPs frequently carry out behavioural screening of emotional, conduct, attentional, pro-social and relationship attributes to determine a child's strengths and needs. The Strengths and Difficulties Questionnaire (SDQ, Appendices 19 and 22) (Goodman *et al*. 2010) is one such instrument in wide use in RoI. This is a screening questionnaire used with CYP aged 4-16 years. It examines twenty five behavioural attributes, which are broken down into five categories: conduct disorder, hyperactivity, emotional symptoms, peer problems and pro-social behaviour. Scoring is on

a 0 (not true) to 2 (certainly true) basis with high scores on the initial four scores representing difficulties and high scores on the pro-social subscale representing strengths. The SDQ was standardised in the UK in a national survey of child and adolescent mental health; this sample consisted of 10,483 participants aged 5-15 years. Its potential has been recognised for the identification of child psychiatric conditions, including emotional disorders (Goodman, *et al.*, 2000).

In judging whether to refer a child to health services, discussions and judgements at school relate primarily to the level of impact on adaptive functioning, as is apparent in the particular school context, and whether a threshold of impact on adaptive functioning has been reached (Rothi *et al.,* 2008). Parents and children clearly have a role in these decisions. In my experience, these discussions frequently occur when the impact on adaptive functioning refers to school refusal or other recognisable external or psychosomatic symptoms. Discussions and decisions for less noticeable internalising behaviours, like negative self-talk and low self-esteem, I propose, prove more difficult. Schools, I suggest, should develop procedures to identify these internalising behaviours and intervene early.

Finally, there is comment also in the literature about the benefits of mental health screening in schools. Weist *et al.*, (2007:53) argue that screening students for emotional/behavioural problems has '*the potential to be the cornerstone of a transformed mental health system'.* They point out, also, that school-based mental health screening can be viewed as controversial in terms of a perceived government intrusion or violation of a family's right to privacy. While there are clear benefits to early identification, in my experience the availability of trained staff for this work (e.g. teachers or health professionals) who could subsequently deliver interventions, would be problematic in RoI.

To summarise, it is apparent that anxiety is a complex concept which can affect many domains of children's functioning in the short and longer term. Because of this link to life outcomes the prevalence of anxiety among young people is a cause for concern. As an EP I can screen for anxiety. I do not diagnose it, but I am well-placed to support anxious children in school through the NEPS model of service on an individual, small group or universal level (i.e. whole class). The next section will examine relevant, school-based interventions for children which are receiving increasing support in Ireland's primary schools.

Intervention

Support for anxious children in schools

The National Council for Special Educational Needs (NCSE) (2014) in the RoI has proposed the adoption of principles cited in Mitchell's (2010) review, whereby best practice involves '*allocating resources to early identification and intensive education for students who struggle with learning'* (NCSE, 2014:107). This appears to align well with the European Agency for Development in Special Needs Education (EADSNE, 2013a) position on the provision of teaching resources for children with special educational needs which proposes that resources be allocated to all learners without the need for categorisation or labelling which *'can have negative consequences, such as segregation and low expectations' (EADSNE 2013a:61).*

Teachers and psychologists work in distinctly different contexts and frequently with different childhood issues. It is interesting nevertheless, to explore where common ground exists among professionals (e.g. clinical and educational psychologists) in the management of anxiety. An examination of clinical manuals for health professionals (e.g. Carr, 1999) and education guidance policy for teachers in relation to mental health can shed some light on whether common ground actually exists. Carr (1999), in the manual '*Handbook of Child and Adolescent Clinical Psychology: A Contextual Approach'*, proposes that a multi-systemic anxiety management programme should contain psycho-educational advice, some individual exposure and exploratory work, family and school involvement in treatment, cognitive restructuring and relaxation. Carr provides an explanation of the principles of clinical practice for each of these elements. Many of the principles contained in this handbook are reflected in DES recommended programmes (e.g. FRIENDS), where cognitive restructuring and relaxation are key elements. However, crucial differences are apparent in some elements for example exposure to feared stimuli until habituation occurs. The practice of exposing a child to a fear stimulus needs careful consideration by school psychologists and teachers alike, as it would represent professional and ethical challenges for teachers in particular. However, some common ground between clinical and educational management approaches is apparent.

Within education policy, the recently published policy document for schools, '*Well-being in Primary Schools'* (DES, 2015), the guidance for teachers clearly states that mental health is

a shared responsibility between parents and teachers. Teachers should work from the inside out, building their own resilience and coping strategies in the first instance, while fostering connectedness to school among children as a key protective factor. The guidelines state that schools should develop an '*evidence-based plan'*, best suited to the child's particular needs, while considering where, when and by whom an intervention will be delivered to the children who are deemed to need such an intervention plan (DES:21). One could ask whether teachers are equipped to determine what represents an acceptable level of 'evidence' in regard to a resiliency/ wellbeing programme, or whether this is ethically and professionally a task beyond the capacity of many schools in relation to anxiety. These guidelines contain a useful caveat though, stating that the guidance should be seen as '*evolving'* and may *'need adaptation in light of future new perspectives'* in mental health and wellbeing *(DES, 2015:3).*This is arguably a positive acknowledgement by the DES that further capacity building for schools and teachers in this area will be needed in the future.

Potential barriers to interventions

A potential barrier to implementation of mental health interventions in schools relates to how this work is perceived by teachers. Mental health is not school business, it has been argued, and '*addressing the emotional health and mental health needs of youth goes beyond the purview of the public school'* (Mayer *et al.*, 2009:93). Also, even though we know that cognitive behavioural approaches have been recommended by the National Institute for Clinical Excellence for depression and anxiety (NICE, 2005), there is a lack of understanding of the moderators and mediators that may impact intervention strategies within schools (Lochman, 2000). The social ecology of the school, for example, can represent a risk factor for the development of mental health disorders arising out of coercive teacher and student interactions. Stand-alone, add-on, internally marginalised, mental health programmes, delivered by educators who are themselves '*beyond weary*' are not sustainable (Mayer and Acker, 2009:101). What is needed is a shift of paradigm and the adoption of a public health perspective in relation to mental health services, in the same way as we prioritise early immunisation for infants (Mayer and Acker, 2009). **School-based initiatives**

Delivery of '*scaled-up school-based therapeutic and social competency interventions'* should be embedded in school curricula in a way which protects teacher time and student engagement (Mayer and Acker, 2009:20).Time, cost, availability, commitment and location distance have been cited as barriers to community health services and have led to a

conceptual shift in the implementation of mental health programmes in education (Jorm and Wright, 2007).These are certainly relevant factors in the widely-dispersed rural catchment area where this research is located.

There seems to be emerging support for mainstream school-based intervention in the USA. The President's New Freedom Commission Report (USA, 2003) has also sought improved school mental health programmes citing the link between mental health intervention and educational outcomes. This report strongly supported the use of an epidemiological approach in relation to mental health where every school should identify students who are (1) typical and not at risk (2) students with an elevated risk and (3) students who have already developed mental health problems. It proposed that school-wide primary prevention programmes should serve to improve school learning environments and promote good mental health and that secondary prevention activities should identify and target at-risk students through small-group and individualised activities. New Zealand (Mental Health Foundation of New Zealand, 2001) and the United Kingdom (DFE, 2011) have also developed national frameworks for the mental health of children.

Mental health policy documents in RoI, such as Reach Out (2005) and 'The CAMHS Report' (2009/2010), mirror this support for prevention programmes. Here mental health services are almost exclusively delivered to primary school children outside of school despite the proposal that '*treatment programs placed in schools circumvent many of the barriers that are often associated with children accessing off-campus services* (MacLoone *et al.*, 2006:233). A number of authors have noted the importance of basing the guidance for teachers on the dynamics that exist in the natural settings of home and school in the first instance (Imich, 1998; Johnson and Wintgens, 2001; Cline and Baldwin, 2004). Imich (1998) points out that the intervention should be early and should adhere to the principle of least intrusive and disruptive intervention and logically that it should be school-based.

Overall, the literature reveals little evidence of an integrated identification and/or intervention practice between clinical and education services even though it frequently points to the importance of not confining treatment to a clinic or hospital setting (Manassis *et al*., 2008). However, there is unprecedented pressure in schools to implement evidence-based approaches to demonstrate accountability (Shernoff and Kratochwill, 2007). Some have pointed out the obstacles to school-based intervention including the pressure for providing both psychological and academic services that strain schools in a system

preoccupied with standardised testing rather than non-academic support services (Mayer *et al*., 2009). Additionally they point to *'chronic incongruence and fragmentation'* both within and between schools and mental health agencies in relation to delivery systems (Mayer *et al.*, 2009:371).

It is important to point out that enhancing students' social and emotional learning (SEL) is thought to positively impact widely on learning. Meta-analysis of a subset of two hundred and thirteen school-based universal SEL programmes, for example, shows an eleven percentile gain in academic performance (Durlak *et al.*, 2011). Additionally, there are compelling conceptual rationales based on empirical findings for links between SEL competencies and school attitude and performance. Students who are self-aware and confident about their learning capacities try harder and persist for longer in the face of challenges (Aronson, 2002). Students who use problem-solving skills, organise their approach to work and set high academic goals learn more and get better grades (Duckworth and Seligman, 2005; Elliot and Dweck, 2005; Zins and Elias, 2006). The importance of early intervention to counter premature withdrawal from school and to create '*opportunity to enjoy school, complete high school, college and/or university, and become full participants and contributors to society'* has also been highlighted (Van Ameringen, Mancini and Farvolden, 2003:569).

Small group intervention

The impact of small group interventions under Primary Social and Emotional Aspects of Learning (SEAL) (Department for Children, Schools and Families, 2008) in the UK has been evaluated as '*promising*' (Humphrey *et al.*, 2008:100). Four interventions *New Beginnings, Getting On and Falling Out, Going for Goals and Good to Be Me* were evaluated in relation to the social and emotional wellbeing and skills of over six hundred children in thirty seven primary schools. There was positive impact of primary SEAL small group work in a least one domain for each of the four interventions. Although the overall effect size of the interventions was small, data collected seven weeks after the interventions suggested that the gains were sustained. Data from schools indicated that group work impacted positively on learning. Evidence of impact at a wider school level (i.e. attendance and parents) was sparse. This study used triangulated assessment techniques (e.g. child self-report, staff and parent informant measures) and took advantage of a naturally occurring comparison group so participants were not randomly assigned to a control group. Further, the study focused on

the intervention process and outcomes, rather than just on quantitative impact data which emerge from highly-controlled efficacy trials like those reported by Shucksmith *et al.*, (2007).

In commenting on the processes which bring about successful outcomes, Humphrey *et al.*, (2008) recommended a tentative model of good practice for primary SEAL small group work based on data from six case study schools. These include using triangulated referral procedures and the use of role models to provide balance in the group to ensure it is not perceived as a withdrawal mechanism for troubled children. Unsurprisingly, they also point to the need for the facilitator to develop strong rapport and to model social and emotional skills. Sufficient time and space should be provided in an appropriate school setting and additional support should be provided back in the classroom. Of particular interest though within a description of what the implementation of a small SEAL group might look like in a school the authors suggest that

> *The nature of this environment, along with the content of the sessions, has led to the small group work being perceived as a special privilege amongst children in the school and they are invariably excited if they are selected* (Humphrey *et al.*, 2008:97).

Two other issues relating to the implementation of small group work arise from the SEAL evaluation. Firstly, it is interesting in the context of the beneficial impact for school-based CB approaches for anxious children (e.g. Bernstein *el al.*, 2005) that little evidence was found of parental involvement beyond consent in any of the case study schools. Secondly, the child's home circumstances were seen as a '*...barrier to effective outcomes'* by some (Humphrey *et al.*, 2008:99). Consequently the twinning of primary SEAL small group work with family SEAL materials for given groups of children is recommended.

Concern has been expressed by parents about their children missing out on class work when they are withdrawn for group work and by school leaders regarding its impact on class cohesion (e.g. Nugent, 2007). Further, some view the classroom as the unit of inclusion while others see the school as the unit of inclusion and argue for time related targeted individualised instruction (Heward, 2003). The predominant model of support in RoI's primary schools involves withdrawing students from their classroom on a one-to one or small group basis, but there has also been a call for greater flexibility in the models of support provision for students in schools (e.g. Travers *et al.*, 2010; NCSE, 2014). This call has related

almost exclusively to 'within school' models like team teaching, and '*a flexible interacting continuum of placement options to meet the needs of all students'* (Travers *et al.*,2010:256).

In a review of international models of best practice for pupils with SEBD, 'The NCSE Report' (Cooper and Jacobs, 2011), recommends a greater focus on early, school-based intervention in RoI. Traditionally interventions for anxious children have been delivered by clinical professionals (e.g. clinical psychologists) in clinical settings. However, recent findings show schools to be a suitable place for CBT-based interventions. The report indicates that educational professionals have demonstrated '*conspicuous success in adopting and applying psychological approaches to SEBD'* (NCSE, 2011:162). In this major review it is argued that '*the educational engagement of students with SEBD improves significantly when mainstream staff are trained in the use of behavioural and cognitive strategies'* (Cooper and Jacobs, 2011:164*).* This recommendation is not without criticism. Others argue that the effectiveness of many interventions which are '*translated*' from clinical settings to schools is mixed, and in this regard, issues of treatment fidelity, therapist characteristics, client characteristics, programme language, cultural sensitivity and social validity are crucial (Lynn *et al.,* 2010). This study's use of a targeted group and a universal group is therefore timely in the context of discussion about new models of support for children with BESD.

Interventions based on cognitive behavioural principles.

Some have posited that there is good news and bad news in relation to intervention for anxiety. The bad news is that once an anxiety disorder has taken hold the chances of spontaneous remission are not high (Lebowitz and Omer, 2013). When individuals become accustomed to avoiding situations, for example, they miss out on opportunities to learn how to cope. The good news is that cognitive behaviour therapy (CBT) has been found to be an effective way of treating childhood anxiety. The CBT approach has been described as a '*diverse collection of complex and subtle interventions'* which share core characteristics, namely: an emphasis of psycho-education, a commitment to a tailored, evidence-based treatment, a functional analysis of the presenting problem, a focus on relapse prevention and generalisation of skills (Compton *et al.,* 2004 cited in Stallard, 2005, 129). The literature reveals growing evidence that early, school-based, social and emotional learning programmes improve students' social and emotional skills, attitude, behaviour and academic performance compared to students who do not complete these programmes (e.g. Durlak *et al.,* 2011) and that interventions for anxious children based on CBT principles in particular

(Beck, 1979) have growing support internationally (In-Albon and Schneider, 2007; Bernstein, 2008; Silverman *et al.*, 2008; Chiu *et al.*,2013).

Unsurprisingly, there has been a rapid proliferation of research investigation into the use of cognitive-behavioural intervention approaches in the context of childhood anxiety. Schonfield and Morris, (2009) cited in Mayer *et al*., (2009) adopted the criteria of the American Psychological Association's Division 12 (Clinical Psychology) Task Force on the Promotion and Dissemination of Psychological Procedures. They identified that the primary goal of CBT is to help children learn to recognise signs and symptoms of their anxiety and to employ coping strategies to reduce or eliminate those symptoms. The authors firmly evidence the long-term effectiveness of four programmes *FRIENDS for Life*, (Barrett, 2004) *Cool Kids* Child and Adolescent Anxiety Program (Rapee *et al*., 2006) Social Effectiveness for Children (Beidel *et al.,* 2004) and Skills for Academic and Social Success (SASS, Masia *et al*., 1999). They point out that while the efficacy of these programmes has been established within clinical settings more research is needed with *'children who are at high risk for developing anxiety disorders'* (Mayer *et al.,* 2009:228).

Additionally, research from clinical settings appears to provide some support for group-based CBT. Barrett (1998) for example randomly assigned sixty, 7-14 year olds to either group CBT (GCBT), group CBT plus family (GCBT+ FAM) or to a wait-list. The outcomes show that seventy one per cent of the GCBT+Fam and fifty six per cent of the GCBT groups were diagnosed diagnosis-free post treatment as compared to twenty five percent of the wait list. An eight week psycho-educational intervention with socially anxious children in Greece involving cognitive restructuring, anxiety management and social training with forty participants led to a significant decrease in scales measuring social anxiety, negative interpretation of ambiguity as well as an increase in children's self-reported likeability (Stephanos *et al*., 2013).

It is also apparent, also, that there are some factors associated with failure of CBT as a treatment. McKay and Storch (2009), for example, have indicated that between twenty and forty per cent of anxious youths receiving evidence-based treatments fail to respond positively. The factors associated with treatment failure appear to be varied. Silverman *et al.,* (2008) have found that youths who retained their primary anxiety diagnosis, having received CBT, were identified as having higher pre-treatment levels of self-rated trait anxiety and depressive symptoms than youth who were symptom free post-treatment. Others have

found that pre-treatment, co-morbidity (e.g. having depressive symptoms before treatment) is also likely to be involved in CBT failure among youth (e.g. Liber *et al.,* 2010). Thirdly, it appears that there are cognitive factors, (e.g. self-talk), implicated in CBT failure. Young people's anxious self-statements, such as "*I am very nervous*" and "*I am going to make a fool out of myself*" have been found to be linked with less pre-treatment to post-treatment reductions in their fear, anxiety and depressive symptoms. Rey et al., (2011:1140) argue that *'even if a child or adolescent receives an evidence-based treatment, it cannot be assumed that positive treatment response will ensue'.*

There is sparse and mixed evidence supporting the active involvement of parents with children receiving CBT. A number of meta-analyses have failed to find differences in efficacy between CBT with and without parental involvement (In-Albon and Schneider, 2007). Also, Manassis (2014) in a meta-analysis of the active treatment of eight hundred and ninety four youth, concluded that CBT is an effective treatment with or without active parental involvement. This analysis, however, also suggested that CBT which involves a transfer of control from the therapist to the parent for the use of contingency management approaches to reward brave behaviour following exposure to anxiety-provoking situation, may support long-term maintenance of treatment gains. Of note in these studies is that they relate to clinical settings and in the recent Manassis study the '*heterogeneity in the type of parental involvement'* elicited by the therapist in the interventions examined may have made comparisons difficult (Manassis, 2014:5).

Overall, it appears that there are a wide range of factors associated with CBI treatment failure. Some studies have found that the presence of anxiety disorders in the mothers and fathers of child patients increases the risk of treatment failure (Bodden *et al.,* 2008; Gar and Hudson, 2009). Other studies have not found an association between parental-depression symptoms and treatment failure (e.g. Crawford and Manassis, 2001). Rey *et al.,* (2011) posit that mothers, fathers and youths who report high family dysfunction, and mothers who report high parenting stress, tend to contribute to CBI treatment failure, although insufficient evidence or discussion is provided to support the argument by the authors. However, meta-analyses of the literature consistently show that approximately sixty five per cent of individuals receiving CBIs improve and about thirty five per cent showing little improvement (Mayer *et al.,* 2009). I propose that it is crucial to maintain an awareness of the aforementioned factors (i.e. cognitive factors, co-morbidity at pre-treatment and parental

factors) in relation to optimising the likelihood of positive school-based intervention outcomes for anxious children.

***FRIENDS for Life* (*FRIENDS*)**

Fisak, Richard and Mann (2011) reviewed eighteen anxiety reduction programmes for children under eighteen years of age. These programmes included *MoodGYM, Coping and Promoting Strength,* the *Penn Resiliency Programme* and the *FRIENDS for Life* programme (*FRIENDS*). Twenty one of the thirty one studies involved randomised controlled trials with some using less rigorous methods (i.e. self-report measures). Only four studies had corroborated findings using multiple informant sources such as children, parents and teachers. They examined the effect sizes in order to identify whether the programme made a clinically significant meaningful difference in children's lives and concluded that *FRIENDS* is the programme supported by the strongest research evidence.

FRIENDS is a school-based, positive mental health, universal programme which promotes emotional resilience and reduces anxiety. (Barrett *et al.,* 2000). Reductions in anxiety levels following the implementation of the CB based *FRIENDS* programme by teachers have also been demonstrated in the UK (e.g. Stallard, 2005; Stallard, 2007) and in RoI by Crosbie *et al.,* (2010). These studies found that 18.8 percent of students rated themselves within the 'elevated' anxiety level before the programme (i.e. 1 in every 5.3 students). This reduced to 10.2 per cent (1 in every 9.8 students) following *FRIENDS* intervention. More recently NEPS has carried out research on *FRIENDS* when delivered universally (i.e. to whole class groups) in twenty seven primary schools by teachers to children aged 10 -12 years (N=709) (Ruttledge *et al*., 2014). The study found that seventeen per cent of the sample rated themselves in the elevated range on the Spence Anxiety Scale for Children (SCAC-C) before *FRIENDS* intervention by teachers (T1), while six months later (T3) this had reduced to six per cent.

Most pupils will experience at least mild anxiety in their lives and this programme teaches the skills needed to reduce anxiety and promotes resilience. As such it is beneficial to all pupils, irrespective of anxiety level. The word *FRIENDS* is the acronym that helps CYP to remember the coping steps to follow: F-Feelings, R-Remember to relax, I-I can do it! I can

try my best, E-Explore solutions and coping step plans, N-Now reward yourself, D-Don't forget to practice, S-Stay calm and talk to your support network.

The cognitive behavioural approach employed in the programme holds that a combination of unhelpful thoughts, anxious feelings and body responses associated with anxiety can result in a cycle of on-going and escalating avoidance of difficult situations and loss of confidence in ability to manage thoughts and emotions. *FRIENDS* is a structured, ten-session, CBT programme based on three main CBT principles to support children in these areas of development through (1) Learning/behaviour, (2) Cognitive and (3) Physiological strategies. The learning behaviour component requires CYP to problem solve, use coping strategies for situations which cause them anxiety and then reward themselves for brave behaviour. The cognitive element involves the use of positive self-talk (i.e. green thoughts) and to challenge negative thoughts (i.e. red thoughts). The physiological component involves teaching CYP to be aware of their body clues and to use relaxation as a strategy to self-regulate (c.f. Appendix 5, *Friends for Life* programme).

The evidence base for FRIENDS has been evaluated by, among others, Briesch *et al.,* (2010). Some of the strengths and weaknesses regarding its implementation have been elucidated. Although the programme was initially intended to be used as a universal-level intervention, it has also been used with 'at-risk' or indicated populations. However, some of the studies evaluated by Briesch *et al.,* (2010) have required students to have had a pre-existing diagnosis of anxiety (e.g. Bernstein *et al.,* 2005). One study, Liddle and Macmillan's, (2010), utilized a teacher referral system and did not require this formal diagnosis of anxiety. Reported effect sizes (ES) for these interventions using FRIENDS were in the range of 0.16 – 1.00, with generally positive outcomes for students (Cohen, (1988) gives the following guidelines on effect sizes for the social sciences: 0.1=small, 0.3=medium and 0.5=large). Of relevance for this current study, is that the programme's effect size (ES) for children with diagnosed anxiety, (ES=0.84), were found to be within the range of effect sizes reported for individually delivered CBT, twice that for those with an 'at-risk' profile (ES=0.44), and four times greater than for the general population (ES=0.24). These reported programme effect sizes, overall though, appear to support the validity of using FRIENDS in targeting the anxiety of children deemed to within 'at-risk' levels in schools, when time and resource '*constraints dictate the scope of service provision'* (Briesch *et al.,* 2010:161).

Some weaknesses have also been found in FRIENDS programme implementation. Smaller effect sizes have been observed when the programme is delivered by teachers, for example (e.g. Briesch *et al.,* 2010). Additionally, in the fourteen studies evaluated by Briesch *et al.,* (2010), most used questionnaires/rating scales to evaluate anxiety symptomatology, with diagnostic interviews only rarely used. Weak screening results were found to be used in the determination of clinical categorisation of anxiety in participants and external evaluations of programme effectiveness were only occasionally used in the context of examining change in diagnostic status.

The use of self-report data, in conjunction with many pre and post intervention FRIENDS programmes, has also been questioned for children with anxiety disorders, for whom the tendency to provide socially desirable responses may be more common (Dadds *et al.,* 1998). Adding to this view, is some evidence that parents' reports support significant positive effects, while self-reports from children do not indicate as much positive gain (Bernstein, *et al.,* 2005). This raises the need for multi-method assessment, especially when implementing the programme with students who have elevated anxiety levels. Despite their commentary regarding the limitations of the FRIENDS programme, Briesch *et al.,* (2010:165) conclude that it '*may be a promising intervention',* but that the literature base would benefit from additional investigations conducted *'in applied settings with typical implementers (e.g. school psychologists) to explore issues of cost, feasibility and flexibility'.*

In summary, this section has identified support in the literature for interventions that employ flexible models of support including small group work using CB principles. Despite support for group work the literature reveals little about the impact of this programme when delivered at a targeted level to sub-clinically anxious children. The literature reveals that *FRIENDS* for *Life* has strong support internationally, despite comment on its limitation, but also that it has been used mainly at a universal level. No literature about its application by an educational psychologist with children for whom anxiety is indicated has been located. This study attempts to fill this gap. The next section examines the role of the EP in schools in supporting children with such needs.

The role of the educational psychologist

The specific roles of EPs, in relation to direct intervention work with children, appear variable across jurisdictions. The British Psychological Society, (2002:4), states that the

primary focus of EPs is '*on the wellbeing and needs of young people'.* In a UK study, however, teachers indicated that the educational psychologists in the UK have changed the nature of their service to a more '*hands off'* approach where EPs observe, assess and recommend (Rothi *et al.*, 2008:127). The authors argue that while it is important to stress that EPs are not mental health professionals, their education and psychology backgrounds means that they can make a valuable contribution to schools where there is a diversity of special education needs. It has also been pointed out that educational psychology is increasingly at risk due to market forces and schools' ability to directly commission therapy services. It has also been suggested that educational psychology '*risks drifting from the provision of therapy services unless its role within the market place is adequately addressed'* through training in core therapeutic functions (Pugh, 2010:397).

Since the publication of the Green Paper *Every Child Matters* (DfES, 2003), the UK government has proposed a wider and more radical engagement with children's development. However, there has been '*a paucity of evidence to demonstrate what educational psychology services are able to contribute to children's development in the round, at an individual, group and institutional level'* (Baxter and Frederickson, 2005:89). It has been posited that the profession is well placed to add value through preventative work with children, but that an evidence base of effective practice needs to be developed to '*provide the professional with a confident role in delivering services which have impact'*(Baxter and Frederickson, 2005:99).

Finding greater relevance and alignment with wider policy appears to be a task for the profession in the UK and RoI. In this regard, Cameron (2006) identified five dimensions of practice which can make the work of EPs distinctive and bring relevance and power to their roles within ever evolving policy and practice demands. These he outlines as *(i) adopting a psychological perspective to human problems; (ii) uncovering/mediating psychological knowledge to create situations with specific outcomes; (iii) employing psychological knowledge to create explanatory models of complex human problems; (iv using evidence-based strategies for change; and (v) sharing and promoting big ideas from psychology* (Cameron, 2006:289). Additionally, in applying these five principles it is argued that EPs can demonstrate that psychology is concerned with promoting evidence-based support for individuals and groups in society and most certainly not about '*putting people in pigeonholes or labelling people, even though it has often been employed for this purpose'* (Cameron,

2006:301). It is noteworthy that dimension four (iv) of Cameron's practice dimensions is captured in the most recent NEPS policy which guides EPs to promote evidence-based practices and programmes to improve academic and social-emotional outcomes for all learners (NEPS, 2013).

Online information retrieved about the role of EPs in the US, UK and RoI indicates differences in relation to the way EPs work with children, teachers and families. In the United States, for example, The National Association of School Psychologists (NASP) describes EPs as '*school psychologists'* and states

> *School psychologists partner with families, teachers, school administrators, and other professionals to create safe, healthy, and supportive leaning environments that strengthen connections between home, school, and the community (NASP, 2014).*

The British Psychological Society (BPS) states that *'education psychologists work in a variety of ways, ... offer consultation, advice and support to teachers, parents, the wider community as well as the young people concerned, ... research innovative ways of helping vulnerable young people* (British Psychological Society 2014). In RoI, the EP's role is to use a consultation process aimed at empowering teachers to intervene effectively with pupils (NEPS, 2014). These role descriptions show slight, but perhaps significant, variation in the EP's role in relation to intervention for SEBDs and the positionality of participants. While the US model suggests a level of partnership with families, and community effort, the British and Irish models emphasise a consultation process with teachers as opposed to a partnership with families approach. Additionally, in my experience, little emphasis has been placed on therapeutic intervention or direct work with vulnerable populations. This needs to change if EPs are to achieve greater relevance in the market place (i.e. schools). Thus, it is necessary for EPs to *'reflect on the profession's current involvement'* in schools and to consider moving towards a profession with *'highly skilled generalists capable of applying therapeutic skills to a wide variety of situations and contexts'* (Pugh, 2010:397).

It has been proposed that because schools offer access to treatment for all children, and a venue for prevention through early identification of mental health problems, EPs are uniquely positioned to operate at a macro-level to effect change (Cameron, 2006; Pugh, 2010; Fox, 2011). As school psychologists, we are well-positioned also to evaluate the needs, resources and goals of a whole school to make an impact on bridging the gap between

research and practice in mental health promotion. But this, in my experience, has not always been a priority for EPs in RoI. Splett and Maras (2011), reason that a focus in the training of EPs in building competency in evidence-based practices (EBPs) among individual students has, in fact, stymied the progress at a broader level for school psychologists' roles as systems-change agents.

Other reasons for slow progress in mental health promotion at the macro level in schools in the RoI are apparent, and relate to a number of competing, service-objectives, which exist within the profession of educational psychology. Firstly, there has been a constant draw on EP services to asses and advise on the resource needs of individual students through casework (i.e. the micro level). Added to this has been an increased emphasis on 'doing what works', and using evidence-based practices and programmes (EBP) to produce positive measurable outcomes from implemented programmes. Glasgow *et al.,* (2003) have suggested that the idea of establishing the efficacy of a practice, in the research setting, and expecting consequent effectiveness in practice through linear transfer is flawed. The transfer process, it is suggested, must consider a community-centred model of EP practice, and work within the culture, values, concerns and existing practice setting '*before widespread adoption of EBPs'* can be achieved (Splett and Maras, 2011:388).

Educational psychologists as practitioner researchers

The importance of practitioner research for EPs also seems to be emerging internationally. In the US it has been argued that EPs as researchers have not taken seriously enough the importance of research in their own practice to reaffirm their relevance in the education system (Patrick *et al.,* 2011). Instead EPs have preferred to focus their writing for academic audiences or other EPs. They have neglected to emphasise the connection between their research and practitioners' needs, and this has negatively impacted the relevance of the profession for teachers and teaching. Fortunately, in recent years, NEPS has begun to address this issue. In 2012 the Research Advisory Committee (RAC) was established with the aim of supporting research and development as a broadly based integral part of the operation of NEPS. Service priorities which highlight the need for evidence-based interventions have been communicated to schools (e.g. '*Psychologists will support schools in implementing key evidence-based intervention programmes'* (NEPS, 2013). Additionally, mental health has been prioritised as a priority research topic during the period 2012-2016. This has created timely support for my research activity.

When EPs carry out research *with* children the principles which guide pupil participation in decision-making about their own futures, which are enshrined in documents such as the United Nation Convention on the Rights of the Child (UN, 1989), need to be considered. The RoI ratified the UN Convention in 1992 and Article 12 stipulates that the child's view is taken into account in all matters which affect them. The National Children's Strategy (2000-2010) identified three goals crucial to supporting children's full participation in life. These state that children should '*have a voice in matters which affect them' (Goal 1),* that their lives '*will benefit from evaluation, research and information on their needs, rights and effectiveness of services'* (Goal 2), and the children '*will receive quality supports and services to promote all aspects of their development' (Goal 3)*.

Harding and Atkinson (2009) propose that EPs should develop ways to enable the views of the child to emerge while others caution about the use of questions and answer techniques to elicit views as this method means that the '*adult keeps the upper hand'* (Lewis, 2002:113). Within the literature relating to pupils with social and emotional behaviour difficulties generally, and in relation to anxiety specifically, the voice of pupils is one of the least heard despite arguments for the potentially insightful value of this voice (Davies, 2005; Cefai and Cooper, 2010; Hodkinson, 2010). Furthermore, youngsters are not consulted about the methods which they feel would be appropriate to gather their views about their educational journey (Prout, 2000; Laybourn *et al.*, 2001).

Frameworks for programme application

Egan (2002), in his analysis of what constitutes skilled helping, has pointed out that there should be a therapeutic or helping dialogue between helpers and their clients. He identifies four requirements of true dialogue: turn taking, connecting, mutual influencing and a co-creation of outcomes. Egan stresses that '*a respectful, empathic, genuine and caring mind set might well lose its impact if the client does not see these internal attitudes reflected in your external behaviours'* (Egan 2002:70).

It has also been pointed out that creative therapeutic techniques are useful with vulnerable populations such as children who have been abused (Trice-Black, 2006; Ware, 2004). Stories, painting and role play have all been used to help the children who frequently find it difficult to play following traumatic experiences. The use of metaphor has also been

commented on in the literature and has been defined as one thing becoming a symbol for another (Lackoff and Johnson, 1980). There is an underlying assumption that if some elements of the selected metaphor agree with aspects of reality then other aspects will be consistent also (Meier, 1998). The usefulness of therapeutic metaphor lies in the ability of the user to connect with, and personally relate to, the metaphorical picture (Geldard *et al.*, 2009). Further it has been proposed that children's metaphors can help facilitate awareness of emotions and that this learning transfers to the child's practical reality without the need for verbal discussion (Ariel, 1992; Close, 1998).

While there is recognition that the therapeutic relationship is very important (Kazdin and Kendall, 1998), research exploring this relation is rare (Stallard, 2005). Children often present at the onset of therapy as '*reluctant, unwilling clients with little ownership of any problems or need to change'* (Stallard, 2005:92). Stallard, (2005) proposes that the relationship with clients should be embedded in key principles captured by the acronym PRECISE and seen in Figure 2.2 below. The PRECISE principles, he argues, can help to inform a '*good therapeutic relationship'* (Stallard, 2005:92) during the change process.

Figure 2.2 The PRECISE principles

P	based on **P**artnership working
R	pitched at the **R**ight developmental level
E	promotes **E**mpathy
C	is **C**reative
I	encourages **I**nvestigation and experimentation
S	facilitates **S**elf-discovery and efficacy
E	is **E**njoyable

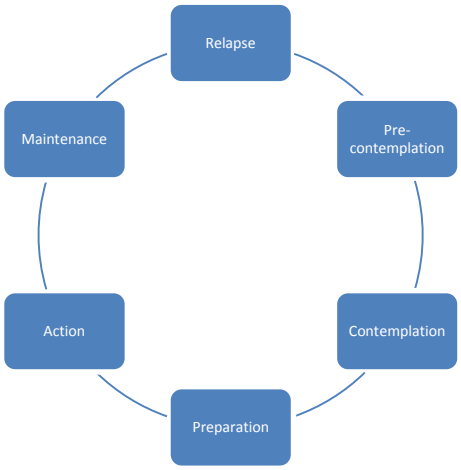
Bannister, (2003) suggests that children, when they engage with creative methods and materials, are working in '*the space between'* or *'an intermediate space necessary for their development'* (Bannister, 2003:20). Within this space the therapist must not be intrusive or overly prescriptive and must nurture creativity. Part of this creativity is the children's use of metaphors to carry their activity. This seems reasonable in light of argument which proposes that metaphors can influence the unconscious much more than logical language (Cox and

Theilgaard, 1987). Bannister argues that metaphor provides a bridge, a space between for the children to *'share their experiences without embarrassment and to create solutions together'* (Bannister, 2003:113).

Beaver (2011) points out that establishing a trusting relationship is the single most important aspect of rapport building with clients. A key element of this rapport building is the need for the psychologist to remain neutral in their partnership with children and to ensure that '*...no allegiances are formed with individuals or subgroups within the system'* at the expense of another group (Beaver, 2011:39). Beaver prompts psychologists to maintain a 'meta' perspective and not to become a part of the system. Additionally, the author states that Rogerian-based principles of warmth, genuineness and empathy are relevant for EPs, but argues that more specific, rapport-building needs to be integrated into practice. Relevant EP skills for building these trusting relationships include the need to show behavioural flexibility, sensory acuity and ability in the EP to reach congruity between the non-verbal and verbal messages given to children.

Stallard (2005:92) points out that '*research into specific aspects of the therapeutic practice is lacking'* and that the Stages of Change model for primary therapeutic focus Prochaska *et al.*, (1992), as seen in Figure 2.3, may have usefulness in application of CBI programmes with anxious children.

Figure 2.3 The stages of change model (SOC) (Prochaska *et al*. (1992)



The model holds some usefulness for judging the pace, actions and receptivity of the children to programme content and activities which may elicit resistance if introduced too early. Stallard (2005) posits that it may serve as a guide to a psychologist who needs to moderate

the pitch and focus of therapy inputs. Because the group of children who are targeted in this intervention have been showing anxiety for some time, readiness for change through the *FRIENDS* programme is a primary consideration.

The SOC model conceptualises the person moving from being unwilling or unmotivated to make any change to a consideration of possible goals for change and then deciding to make some small change. It focuses on a person's readiness at pre-contemplation stage and on whether they have ownership, motivation and/or interest in change. At the contemplation stage potential areas for change will have been identified but the person may be unsure whether change can be achieved. At the preparation stage the person can discuss potential barriers before taking action. At the maintenance stage the person is encouraged to generalise their new skills. During the relapse stage the task is to help the person to reflect upon, identify and re-deploy the new skills. No literature has been located as to whether facilitators of the *FRIENDS* programme have reflected on participants' readiness for change. This model I believe has potential to inform the pace and focus of programme delivery.

Conclusion

The literature reviewed reveals that anxiety is a complex, multi-factorial condition with a worryingly high incidence, which can impact broadly on the adaptive functioning of CYP across a lifespan. While psycho-medical, clinic-based treatment models have traditionally been used with anxious children, there is evidence of emerging broader understandings of the utility of dimensional approaches to assessment and school-based early intervention, as a pillar for overall community mental health. These emerging changes could provide a basis for wider access for children with sub-threshold anxiety in schools without recourse to a formal anxiety diagnosis. Consensus, however, is lacking on what constitutes normal, mild and clinically elevated anxiety.

A positive development internationally is the emerging evidence base for the *FRIENDS* programme but '*more studies are needed that evaluate the effectiveness and efficacy of the delivery of CBTs within 'natural' settings such as school, where the complexities of children's needs may be fully explored.'* (Rait *et al.*, 2010:116). On a macro level the NEPS' framework for practice, which I use as an EP, clearly acknowledges that in terms of mental health issues, school '*context counts'* (Gutkin, 2009:478). EPs are ideally positioned in their

relationships with schools to '*systematically evidence what the most powerful ingredients are for children and young people receiving CBT'* (Rait *et al.*, 2010:117).

Additional to the lack of consensus on what constitutes mild anxiety, there is little or no specific research on how EPs apply the *FRIENDS* programme in a school-based, targeted group setting to strategically support these reticent, mildly anxious children. I set out to fill this gap by exploring the perceptions, impact and professional practice implications of such an intervention with three such mildly anxious children in a rural primary school. In this regard this is new territory for the educational psychology profession in RoI.

The next chapter outlines the methodological approaches adopted in this interpretivist research. It describes the participatory action research (PAR) and constructivist grounded theory (CTG) strategies I used during the case-study based intervention. My approach to sampling, along with my attempts to ensure the care and safety of the children, are also discussed.

Chapter 3 Research Methodology

Introduction

This chapter outlines the methodological approaches adopted in this small-scale study, which sought to fill a research gap in targeted intervention for mild to moderately anxious children. Specifically, it sought to explore the perceptions, impact and professional practice implications of an intervention using the *FRIENDS for Life* programme with three such anxious, reticent children in a small rural primary school in the RoI. It begins with a discussion about the philosophical underpinnings of the study and the use of participatory action research (PAR) with constructivist grounded theory (CGT). A description is provided of the research design and the nine interventions sessions, with three girls selected for the study who received the *FRIENDS* programme. The school's learning-support teacher (LST), on my request, acted as an observer in the learning-support room during intervention sessions 1 to 6. She was simply asked to observe and record her observations during programme implementation. Additional, specific guidance was deliberately not given to her, in order to minimise my influence, and to align her, in as much as was possible, with the grounded theory approaches which point towards ground up observation of what is deemed to be of greatest interest (Charmaz, 2014:7). Data collection and analysis procedures are then explained. They show the iterative approach to session design, data collection and analysis commensurate with the integrated PAR/CTG approach selected. The chapter concludes with a discussion about ethical practice, research quality and critical reflection.

Philosophical underpinnings

This research draws on interpretivist principles and is concerned with '*how the social world is interpreted by those involved in it'* (Robson, 2011:24). It is founded on the principle that there is not one objective reality (or absolute truth) but that there can be as many realities as there are people. The task of the researcher thus is to understand these multiple subjective constructions of reality (Burr, 2003). My epistemological stance holds that knowledge is based upon perspective and on the '*dialectic relations among respondents and the researcher'* (Lomborg and Kirevold, 2003:194). The research is therefore based on a transactional or subjectivist epistemology which assumes that we cannot separate ourselves from what we know. The investigator and the object of investigation are linked such that

who we are and how we understand the world are central parts of how we understand ourselves, others and the world.

As stated earlier, my ontological position rejects the argument that reality is external to the individual and that phenomena confront us as external facts. Within this study's research paradigm the ontological view of reality is that it is nominal. Emphasis is placed on what is unique and particular to the individual's experience (Burrell and Morgan, 1979) and on individuals' social interactions. This research, therefore, focused on the perceptions of children, their parents and teachers in social contexts within this interpretivist paradigm of social constructivism which asserts that social phenomena *'are not only produced through social interaction but that they are in a constant state of revision'* (Bryman, 2008:19). My research paradigm holds also that knowledge is indeterminate. It does not claim universal truths but accepts the notion of subjectivity and the personal involvement of the researcher in constructing knowledge and beliefs.

The interpretivist paradigm adopted focuses on action and behaviour with meaning. As such, Cohen *et al.,* (2011:17) argue, that the focus is on '*intentional behaviour'* which is future orientated. Individuals play an active role in the '*social construction of their social reality'* and the categories people use in helping them to understand the natural world are in fact social products (Bryman, 2008:20). Meaning is constructed for these categories through social interaction and is represented through language. The researcher's task, within this social constructivist approach, is to describe and interpret voluntary human behaviour specific to the particular context for individuals, as opposed to looking for general laws describing behaviour. There is no claim to generalisability of findings from this study.

My actions were underpinned by assumptions within the symbolic interactionist tradition (Mead, 1934). These emphasise that '*language and symbols play a crucial role in forming and sharing our meaning and actions*' and that interpretation of events and actions in situations are '*reciprocal processes, each affecting each other'* (Charmaz, 2014:262). In this regard, I believe, that the anxious children's verbal and non-verbal actions with objects (e.g. interactions with symbols, their writing and drawing) enable them to convey subjective meaning. Additionally, I could not make any prior assumptions about what was going on in any of the research situations for a child. Within the research, children's actions are understood as, not simply a consequence of psychological attributes such as attitudes, drives or personalities, or determined by external social facts such as social structure, but as

resulting from a '*continuous process of meaning attribution which is always emerging and in a state of flux and subject to change'* (Cohen *et al.*, 2011:20).

The research challenge to work with three variably anxious children shaped my selection of methods. In this regard, I selected constructivist grounded theory (Charmaz, 2000, 2006, 2014) and participant action research (Kemmis *et al.*, 2014) as the most suitable combination of methods to sustain my participation and draw knowledge from within the intervention sessions. A description and rationale for the use of these two approaches is now provided.

Constructivist grounded theory (CTG) and participatory action research (PAR)

At the outset, it is important to point out that the literature reviewed evidences two distinctly different views of grounded theory (i.e. Glaserian and Straussian versions), and a more contemporary version, constructivist grounded theory (Charmaz, 2014). Glaser's (1978, 1995, 1999, 2003) positivistic position on grounded theory is based on the assumption that an external, objective reality exists. The researcher enters the field as a neutral observer who discovers emerging data through observation. These observable data contain meaning. The researcher then extracts the meaning and develops a valid theory by comparing the emerging data with new data to verify their validity.

In contrast, Strauss' (1987) grounded theory is post-positivistic in that it is acknowledges that the researcher inevitably imposes some shape and sense on the data, and accepts that the researcher cannot be entirely neutral. In this version, the meaning cannot simply emerge inductively from the data but involves some kind of interpretation. The researcher, through a process of constant comparison and use of analytical tools, tries to make sense of the data. As can be seen the position of the researcher is philosophically very different to Glaser's neutral observer role. It should be noted, that Glaser had strongly criticised the latter believing that this approach has the potential to *'force the data to fit researchers' categories rather than letting the data speak for themselves'* (Glaser 2003, cited in Denscombe, 2010:119).

The version of grounded theory proposed is a more recent version than that of Glaser or Strauss. Constructivist grounded theory (CGT) (Charmaz, 2000, 2006, 2014) emphasises the role of the researcher as interpreter rather than a discoverer of reality. It acknowledges alternative perspectives and constructions of reality. In CGT Charmaz (2014:22) proposes that the researcher attends to the

> *production, quality, use of data, research relationships, research situation and the subjectivity and social location of the researcher. Constructivist grounded theorists aim to abstract understanding of studied life and view their analysis as located in time, place, and the situation of the inquiry.*

Thus, this constructivist orientation is that data is constructed within interacting interpretations. The approach, it is argued, is sensitive to, and can accommodate, all of the complexities of a niche population actually found in my research process (i.e. anxious silent children) (Creswell, 2012).

A recognised aim of CGT is to *'elevate everyday empirical knowledge to a conceptual level and to generate a practice-orientated theory that structures practical work and people's awareness of their actions'*(Poulakka, 2013:22). Based on its alignment with my epistemological and ontological stance, and its alignment with the interpretivist role of the researcher, CGT principles and practices were therefore used in '*a systematic yet flexible approach to collecting and analysing qualitative data to construct theories grounded in the data themselves'* (Charmaz, 2006:2). Grounded theory methods increase flexibility when gathering data because they foster *'following up'* on what is happening, and '*because you code and categorise data as you collect them'* (Charmaz, 2014:26). It was indeterminable from session to session how the anxious children would respond to me and each other within the confines of a small group, so this flexibility was crucial.

Justification can also be found in relation to the nature of the intervention programme, *FRIENDS for Life* (FFL). The verbal introductions to the main concepts in the FFL programme are pre-scripted in the programme manual and there is an inferred high expectation of verbal engagement from children (e.g. peer to peer and child to teacher discussion). However, verbal engagement was not a behavioural strength for the intervention children in this study, so all other signs of engagement with the programme needed to be observed as closely as possible during programme delivery (e.g. smiling, looking happy, sharing, writing, looking pleased). '*Following up'* then refers to not forcing preconceived ideas on the emerging data but following behavioural leads identified or designing other ways of collecting data suitable for the anxious children. The concepts which emerged from the interactions with the children drove the direction of the analysis from the ground up. Their interaction with me during intervention created a rich source of data.

Constructivist Grounded Theory also treats research as a construction itself. The theory emphasises that data collection and analysis occur simultaneously and in an iterative process.

It aligns well with the influence of Vygotsky (1962) who emphasises social contexts, interaction, sharing viewpoints, and interpretative understandings. In line with CGT, leads that emerged during the researcher's interaction with the children were followed (e.g. children's preferred way of learning content and skills). These leads allowed the researcher's background assumptions and disciplinary perspectives to alert him to '*look for possibilities and processes'* in the emerging data and to function as an instrument of data collection in the development of a deep understanding of a single issue (Charmaz, 2006:16).

The utility of CGT was valuable, and Charmaz has aptly noted that '*grounded theory has evolved into a constellation of methods rather than an orthodox unitary approach'* (Charmaz, 2008:161). Further, *'grounded theory can complement other approaches to qualitative data analysis, rather than stand in opposition to them'* and can be '*adopted and adapted'* under specific conditions of inquiry, including the situations shaping the research process (Charmaz, 2014:16). Therefore, CTG was used in conjunction with PAR, in the belief that '*the integration of grounded theory and participatory action research can empower clients to inform professional practice'* (Teram *et al.*, 2005:1129).

The term PAR has many connotations. Reason and Bradbury (2001) discuss it in terms of a whole family of approaches which is grounded in the researcher's experience, participation and action orientation. PAR (Kemmis, McTaggart and Nixon, 2014) was used in intervention delivery during the activities of Phases 2 and 4 with the target group. The approach implies that '*the silenced are not just incidental to the curiosity of the researcher but are masters of inquiry into the underlying causes of the events in their world'* (Freire, 1982:30). This approach aligned with my belief that the skills I have acquired in practice as an EP, and as a former primary teacher (e.g. rapport building, judging care and safety, designing programmes), could best be deployed in the context of direct and shared action with the anxious children. In this study I was the main instrument and needed to draw on this repertoire of skills. PAR, I believed, would help me develop a '*practice changing practice'* through which self-reflective dialogue, would serve to open up conversations about *'states of affairs in our worlds'* (Kemmis *et al*., 2014:28).

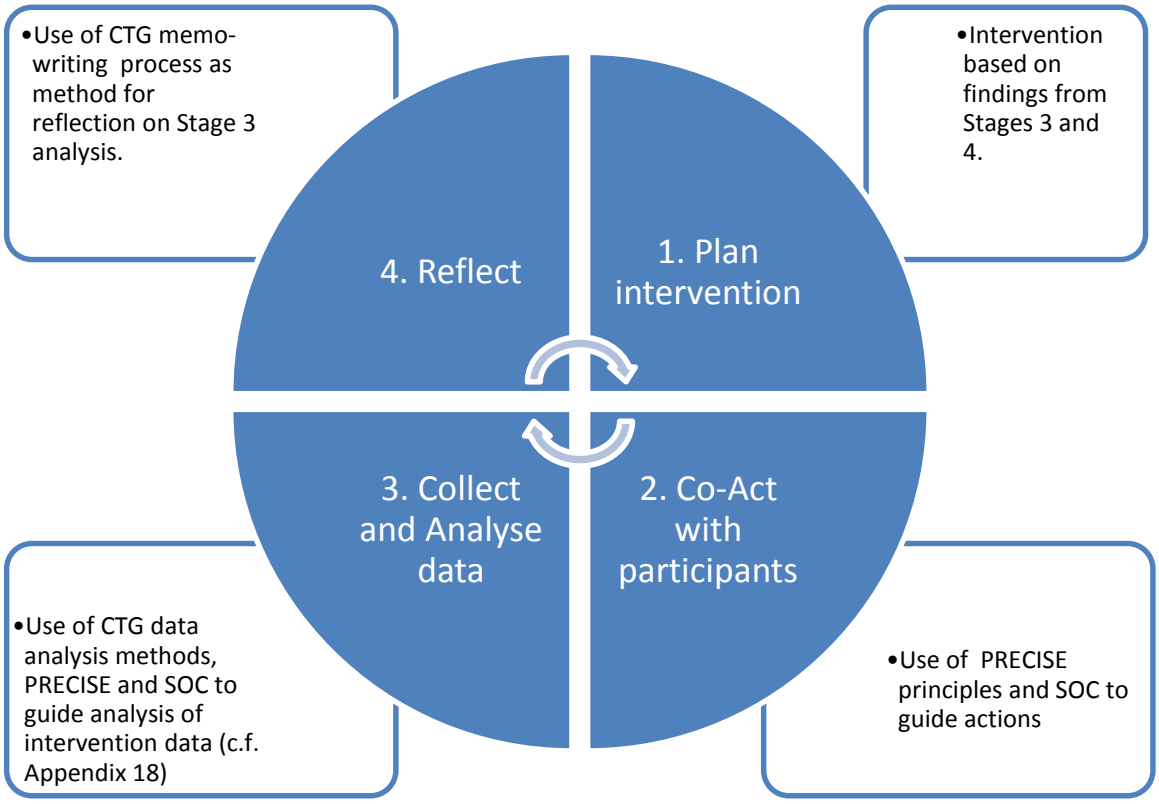
Justification for the use of PAR and CGT can be found within the literature from applied health professionals (e.g. nurses, social workers) and is based on interest in finding useable, valid knowledge in unexplored areas of professional practice, and the need to address contextual power differentials which frequently exist between applied professionals and

their clients (e.g. Teram *et al*., 2005). In the search for valid knowledge from within practice contexts *'the understanding of verification starts in the lived world and daily language where issues of reliable observation, of generalisation from one case to another, of valid arguments, are part of everyday social interaction' and the quality of the craftsmanship'* Kvale (1996:230).Good quality, transparent craftsmanship in PAR can support knowledge claims whose validity is based in the quality of the work itself (Kvale, 2002).

High-quality craftsmanship reflects the continuous checking, questioning, and theoretical interpretation of data that comes with the constant comparative analysis approach used in grounded theory. I hold with Kvale's (1996) view that pragmatic validity, which focuses on the relevance of knowledge for generating action and change, can best be achieved for me as a practising EP through PAR. Kemmis and McTaggart (1998) outline sixteen tenets of PAR which were used to guide my actions in research. These are briefly described in Appendix 4, *Principles and Characteristics of Participatory Action Research,* which relate to approaching the research in a systematic, collaborative way which starts in small cycles and effects authentic co-participation.

A study-specific PAR/CGT conceptual model was devised for my research. It is based on a four stage 'Plan, Co-act, Collect/Analyse and Reflect' cycle of the PAR model underpinning my approach. It can be seen in Figure 3.1. It illustrates the integration of CTG and PAR into a model to generate knowledge, in an iterative cycle of action and data collection from session to session, to sustain my participation in the challenging intervention process.

Figure 3.1 Participatory Action Research/Constructivist Grounded Theory Model



As can be viewed in Figure 3.1 the children's participation was effected through their joint action with me (i.e. Co-act) during the intervention. This involved drawing images together, sharing programme content, taking part in relaxation exercises together, making intervention materials together and sharing stories through writing together. The use of CGT within the model at stages three and four involved the use of the CGT strategy of constantly comparing emerging data and in the use of memos to drive the reflective process after each intervention session. The analysis of data will be explained more fully later.

Research approach

I used a case study approach in this study for a number of reasons. Firstly, the system within which the research took place was bounded by its temporal, geographical, organisational and institutional context (i.e. a four-teacher mixed rural primary school) (Hitchcock and Hughes, 1995). Secondly, case study highlights *'the uniqueness of events and actions, arising from their being shaped by the meanings of those who are participants in the situation'* (Pring, 2000:40). Case study also '*lends itself to the study of processes and relationships* (i.e. in relation to anxiety) *within a setting'* (Denscombe, 2010: 55; Yin, 1994).

My aims were to sensitively explore the perceptions of the children by being a co-participant in an intervention with them in a democratic way. My belief that '*situations are fluid and changing rather than fixed and static'* aligned well with my approach which emphasised flexibility in intervention delivery in order to make adjustments which could optimise the anxious children's participation (Cohen *et al.,* 2011:17). Case study can embrace these unanticipated events and uncontrolled variables, capture unique features that may be lost in larger scale data and can give a strong account of reality (Nisbet and Watts, 1984). This was a strength in my approach with the three anxious children where events may have been unpredictable.

The use of a case study approach for my investigation was also justified as the case itself was '*something that already exists'* (Denscombe, 2011:54). As such, therefore, a natural setting was immediately available for the anxious children. This was vital for their care and safety. Case-study invites researchers to use multiple methods and data sources and holds that the approach works best in the investigation of processes and relationships within a setting. An obvious limitation with the narrow boundaries of this case study is the cost to generalisability. I believe that this can be countered through the representativeness of the study's case. In this regard, this case study with three anxious children is reasonably typical, in that, in my experience there are a number of anxious children in all schools in the region. Prevalence rates appear to confirm this. Additionally, the school selected is typical of the majority of schools in this geographical region. Overall, the selection of a case study approach was pragmatic. It added to the coherence between the epistemological and ontological positions adopted. It facilitated emphases on the uniqueness of the individual within the natural environment and aligned with the interpretivist, qualitative research strategy.

Behaviour checklists (e.g. The Spence Anxiety Scale for Children) were used to aid sampling. A description of this scale is contained in Appendix 19. As an EP I frequently gather qualitative data about children's lives in the school context in order to gain an insight into possible solutions which have ecological validity. This element of my practice involves an exploration of the meanings the students and I give to their learning at school.

Addressing the power differential

'In work with children there is a complex relationship between issues of power, control, responsibility and ethics' which pose challenges (Veale, 2005 in Greene and Hogan:

2005:270).There was an obvious risk that the children would feel insecure in my presence. As a person from a different generation, I needed to **'***acknowledge the status and power differentials which shape (or have the potential to distort) the processes involved in carrying out research with children* (Christensen and James, 2000:31) (Underlining added by writer). I made effort to embrace Davie's (1993) challenge to the psychological community to listen to the child from the perspective of co-participant. This challenge included the need to be reflexive and remain sensitive to the researcher's own cultural, political and social context and to remain reflective about '*the implications of the methods, values, biases, and decisions for the knowledge of the social world they generate'* (Bryman, 2008:682).

In addressing power and generational issues in relation to adults conducting participatory research, Mandell's principles (1991, cited in Randall, 2012) in relation to the 'least-adult' role were pertinent. These state that adults should:

- minimise the social differences between adults and children;
- value children's social worlds as being as important as those of adults;
- try to find shared meaning with children through social activities such as play.

Mandell initially built trust by watching, copying and playing. By joining in play, adults can demonstrate the type of adults they are – '*that is the type who will play'* (Randall, 2012:42) and so minimise the social differences. In introducing the intervention to parents and teachers the researcher explained that play is the primary medium for intervention delivery.

Mandell's principles appear to accommodate well also to the United Nations Convention on the Rights of the Child (UNCRC) principles which view children as social actors and participants in the research process '*as they are in societal life'* (Christensen and Prout, 2002:481). Children should be involved, consulted, informed and heard (Christensen and Prout, 2002). This research process, therefore, attempted to recognise both intra- and intergenerational commonality but also to honour difference. It is acknowledged that as co-participants the PAR/CGT model could never fully address the power differential between the children and me. Children's rights to influence intervention decisions at stage two of the model above were respected at all times, however, and are captured widely in the study's appendices which explain the basis of their participation.

Design

The perceptions, impact and professional practice of an intervention for three sub-clinically anxious children (i.e. The Target Group TG) in primary school were explored. Nine of their peers (i.e. five boys and four girls) from the fifth grade also received the intervention (Universal Group, UG).

The three TG children were identified through screening and multi-informant information (i.e. Pre-intervention interviews with parents and teachers) at their school in January 2014 (T1).I subsequently participated in, and facilitated FFL content delivery, during thirteen FFL sessions, between January and June 2014, with both TG and UG groups. Second interviews were held with teachers and parents of TG children again at T2. Six months later (T3) the teachers were re-interviewed. This information is summarised in Table 3.1.

Table 3.1 An overview of the Sequential Explanatory Design

Time	Procedure	Data collected
T1.Pre-intervention,	Recruitment of school, parents and children through discussions and delivery of *Educator and Carer Seminars*. Screening procedures (T1) and pre-intervention interviews with parents of TG children and teachers	Qualitative and numeric data
Intervention	Both TG and UG groups received the programme together in Phases 1, 3 and 5, in their mainstream classroom and separately in Phases 2 and 4 in the school's learning support room. In total nine intervention sessions were held with Target Group (N=3) separately during Phases 2 and 4.	Qualitative data
T2 Immediately after intervention sessions ceased	Interviews with parents and teachers of TG children.	Qualitative data
T3 Post-intervention phase, six months later	Interviews were held with teachers six months after the intervention was completed.	Qualitative data

Description of a typical *FRIENDS for Life* session with the target group (TG)

Intervention sessions were delivered on the same day each week. I arrived at the school and made my way to the principal's classroom to say hello. Generally, some of the more outgoing children would greet me with an 'Hello Adrian'. This familiarity was helpful and I

encouraged it. Following a short conversation with the principal I proceeded to the learning-support room or remained in the mainstream classroom depending on the session planned.

Shortly afterwards, the principal would ask either the TG or UG children to make their way to me. The order for intervention delivery to groups was alternated each week as indicated in Table 3.2. The children in the TG sat at the 'L' shaped seating selecting their own seats. The following account describes the cycle of actions involved in delivery of the weekly intervention programme session. It should be read in conjunction with Figure 3.1 describing the participatory action research/constructivist grounded theory model.

1. The Planning Stage: The selection and scripting of the *FRIENDS* programme content and activities took place the day before the intervention session. Planning meant consulting the *FRIENDS* manual and deciding the order of activities and the modifications which were likely to make the content and concepts accessible to the anxious children with reference to the trends that had emerged from the earlier sessions. Materials needed to be prepared (e.g. Talking Mat symbols, dry erase pens for MHC cards, Millie story written).

2. The Co-Act stage: I placed my pre-written *FRIENDS* session script close to me on my desk. The learning support teacher sat at her desk and was usually engaged in school-related work adjacent to the group as the children entered the room. She wrote her observations in a diary specifically provided to her for this purpose.

The session began with the writing of the agenda for the session on the white board. This was followed by sharing drawings about a happy event that week on small cards called MHCs (c.f. Figure 4.8). During the session we used various parts of the room. We frequently placed a floor mat in one area which could be used for relaxation. Another area was cleared of desks where children could freely move. A range of materials (i.e. colouring pencils/scissors/ blank A4 sheets of white paper) was available for drawing and colouring. Each week we drew on an A4 page the capital letter of the *FRIENDS* acronym (e.g. the letter F) associated with the particular FFL session, and pinned it to the wall in the school corridor as we progressed through the programme. We also used the materials for story writing. Co-participation in this study refers to the fact that I took part in all activities with the children. I wrote stories, cut out letters, coloured, relaxed, placed symbols on the Talking Mat and shared the tidying up and used MHCs in order to synchronise with them.

The activities engaged in for content delivery, depending on the particular session, were varied. They ranged from non-verbal sharing of drawings, agreeing ideas to make the group a success, one-word guessing of what we had drawn on our MHCs, me reading a story, children writing stories, lying on the floor or in another position while doing the FFL relaxation exercises, listening to stories, sharing objects of interest, listening to me playing guitar at the end of the session, drawing and working with symbols related to programme content (i.e.TM symbols). Activities were frequently adjusted during intervention delivery in order to effect greater engagement with the children.

3. Collect and Analyse stage: When the session ended the children returned to their classroom. I remained in the room for a discussion with the learning-support teacher and to retrieve the notes of her observations. The principal frequently joined us for these discussions. I would subsequently join the staff for a tea break in the staff room where a range of topics was discussed. Finally, the following week's session was scheduled and I left the school. I frequently observed the TG children in the playground as I left.

On return to my office, I recorded the data from the session. This involved writing my observations about how the children had responded to the various activities, about their verbal and non-verbal behaviour and examining any written/drawn outputs. I also read the learning-support teacher's field notes of her observations. The data, collected during the sessions, were immediately entered onto an Excel spreadsheet. The data analysis process followed is outlined in Appendix 18 (i.e. Data Analysis Process).

4. Reflection stage: This activity took place in the days following each session. I frequently wrote memos as I coded and analysed the data. Memos were written into my research diary about new ideas for intervention delivery, about the successes and failures in my approach and about emerging trends in the data which needed to be investigated further. These reflections and the emerging trends in the data informed my planning for the next session. Some of these memos are presented in the next chapter.

Intervention delivery

The flexibility within the school to use both the mainstream classroom and learning-support room locations and to merge groups, when deemed appropriate, for the sessions became a great strength of the intervention as it helped to counter any negative perceptions related to

withdrawal of the TG for support to the learning support room. This will be commented on again later.

The method of delivery for the programme was different for the TG. As the children were anxious and showing communication apprehension during the early sessions, the activities presented were modified for their needs and required them to use little verbal engagement (e.g. Using Talking Mats, relaxing, choosing symbols, using one word guessing).

Creating access for those who are anxious reticent speakers to CB is crucial. In Scotland an interesting new intervention approach for eliciting the views of non-verbal populations known as 'Talking Mats' (TM), (Murphy and Cameron, 2008), has growing support. This is a low-tech augmentative alternative communication technique (AAC) which has been trialled by the researcher in TM training with typically developing children in which participants use picture symbols for communication in the first instance and speech only if the person wishes to talk (c.f. Figure 4.9). It has been described as *'a tool to help people on their journey of decision making'* and *'...a tool that helps both understanding and expression'* (Murphy and Cameron, 2005:3 and 33).

There is a burgeoning literature, also, showing that symbols are situated in the context of a creator who assigns meaning and a user who interprets that meaning (Callaghan et al. 2008; Myers and Liben, 2012). In this study the anxious children, who are reticent speakers, will be given opportunity to assign meaning through symbol use to represent their '*mind on paper'* (Myers and Liben, 2012:201). Some issues have arisen in the evaluation of the images being used with people who have a disability, (Survivor Scotland and Talking Mats). In one study into its usage images which purported to represent thoughts and feelings have caused some difficulty with regard to broad agreement of their accuracy and no simple solution has been found. Reflection on abstract topics (e.g. sadness), through images, it is proposed, requires a high cognitive load. It also requires a flexibility of thought so it may not be helpful for all people with a learning disability.

Activities drew more on the children's own activity preferences as the intervention progressed (e.g. story writing). The delivery schedule which was followed can be seen in Table 3.2:

Table 3.2 Programme and intervention delivery schedule

Phase 1 Mainstream Classroom	Target and universal groups together for introduction in mainstream classroom			
Phase 2 Learning Support Room	FFL Session	**Target Group**		**Universal Group**
		FFL content	Delivery methods	FFL Content
	1	Group Formation Understanding Feelings	PAR/CTG	Group Formation Understanding Feelings
	2	Introduction to Feelings	PAR/CTG	Introduction to Feelings
	3	Body clues and Relaxation	PAR/CTG	Body clues and Relaxation
	4	Paying careful attention	PAR/CTG	Paying careful attention
	5	Changing unhelpful thoughts into helpful thoughts	PAR/CTG	Changing unhelpful thoughts into helpful thoughts
Phase 3 Mainstream Classroom	6,7,8	Target and Universal Groups together Coping Step Plans Learning from Role Models Using Problem Solving Plans		
Phase 4 Learning Support Room	9	Coping Step Plans (Setting goals)	PAR/CTG	Coping Step plans
	10	Coping Step Plans (Red thoughts/Green thoughts revision)	PAR/CTG	Using our Friends Skills
	11	Coping Step Plans (Rewards)	PAR/CTG	Friends skills in song
	12	Using problem Solving plans	PAR/CTG	Friends skills in song
Phase 5 Mainstream classroom	13	Target and universal groups together for final session for 'FRIENDS TV' programme and reward session. Target and Universal groups debriefed.		

Phases 1, 3 and 5 were held in the mainstream classroom for both groups (i.e. TGUG). Phases 2 and 4 were held in the learning-support room for both groups. Session 13 (Phase 5) finished with an in-class mock '*FRIENDS* TV' show where both groups were mixed into groups of four and given the task of presenting a short, fun-based , TV show about people using one of the skills learned in the programme. Data were not collected during this activity which was filmed by the class teacher.

Sampling

Because of definitional ambiguity with regard to what constitutes sub-clinical anxiety, a pragmatic, multi-informant approach was adopted in selecting children for the targeted intervention. Information from anxiety and behavioural checklists was considered by the principal teacher and I. This information was combined with parents' comments and observations (c.f. Appendix 2). Four selection criteria were used, as outlined in Appendix 2, in an attempt to achieve a purposive sample of three children exhibiting study-specific, mild to moderate levels of anxiety within their school environment.

In *'qualitative inquiry the intent is to not to generalize to a population, but to develop an in-depth exploration of a central phenomenon...and thus the researcher purposefully or intentionally selects individuals and sites'* (Creswell, 2012:206). The girls were selected as they had privileged knowledge or experience about the topic. Using participants who are '*information rich'* helps to gain an understanding of the central phenomenon (Patton, 1990:169).

The school is a typical mixed, ordinary (i.e. no special designation) rural school of the region, with four teachers and less than one hundred pupils. Seventy five per cent of county Mayo's schools are similar in size.

Children's participation in research is dependent on adult gatekeepers (Hutchfeld and Coren, 2011) so the FFL programme was introduced to the school principal first. She is also the girls' teacher. I have an existing professional relationship with the staff of the school. The school-based screening process is outlined in Table 3.3 below:

Table 3.3 School-based screening process

1	Following discussions with me the school principal recommended *FRIENDS* to school's Board of Management. During the *Educator and Caregiver* seminar about the programme held subsequently, parents of all fifth class children (N=12) gave consent for their children to participate in the *FRIENDS* programme. (c.f. Appendix1, The *FRIENDS* Club information sheet for parents). At this seminar parents were informed that their children would be invited to take part in the programme in the 'FRIENDS CLUB', in a small group format (i.e. TG) or a large group (i.e. UG). The difference between the groups was explained in terms of the methodology of delivery. One parent (P3) asked that her daughter be assigned to the smaller target group at this point.

2	All children in fifth grade were asked to complete the Spence Children's Anxiety (SCAS-C) Scale by their class teacher (i.e. school principal). Class teacher also completed the SCAS and the Strengths and Difficulties Questionnaire(SDQ) in respect of all fifth class children (c.f. Appendix 19)
3	Selection discussions using data from SCAS, SDQ and teacher knowledge were compared against study specific criteria (c.f. Appendix 2 Inclusion and exclusion criteria for intervention group). Three children, known to me by numeric identifiers only, were identified.
4	Class teacher invited parents of these three children to meet me. She explained that she would like to use school's existing 'Class Rep' nomination system to bring about their participation in the TG. In the 'Class Rep' nomination system children are selected by teachers to become their class class/group representatives in various school initiatives. The approach had most recently been used during an anti-bullying project and previously in the context of a 'Green Schools' initiative. This approach ensured that I did not deliberately impose a new selection process for group work in the school but allowed it to '*...occur naturally'*, thereby ensuring a measure of ecological validity (Cohen *et al.*, 2011:195).
5	Parents met me and gave me consent to meet the children to explain the TG approach and seek their assent. A copy of the project's parent consent form is contained in Appendix 1.
6	The three TG children were individually invited into a child-parent-researcher partnership for the period of the study (Lambert and Glacken, 2011). They gave their consent to participate. The class teacher is a familiar adult who can help ensure that '*the children are capable of giving such assent'* to participate. (American Educational Research Ethics, 2011:152). The child's right to withdraw at any time and the commitment to make frequent contact with each parent was also explained to the TG children. The running of the *FRIENDS* CLUB was explained in detail. They were provided with an information sheet about the TG group (c.f. Appendix 3 OK Form for taking part in the '*FRIENDS* Club'**)** and given opportunity to ask questions or to raise any issues with their teacher later about coming to the *FRIENDS* CLUB. All three children gave their assent.

Child 1 (C1) was considered the most anxious at school. If she missed school she would become stressed. In the playground she rarely initiated conversation and could be observed playing alone. Her parents indicated that she was constantly worrying and looking for problems. Her father described himself as like his daughter when he was younger. Her teacher indicated that C1 rarely initiated conversation in small group activities. Based on her screening scores, and discussions with her teacher and parents, she was judged to exhibit a mild to moderate level of anxiety.

Child 2 (C2) was described by her teacher as a girl who focuses on the negatives and who gives up easily. She frequently complained of feeling sick and frequently sought a lot of attention for relatively small accidents (e.g. a cut on her finger). Her teacher indicated that she is quite talkative. C2's mother indicated that she, herself, experiences mental health challenges, and that she finds it difficult to get up each morning. Based on her scores, on the screening instruments and discussions with her teacher and parents, she was judged to show a mild level of anxiety.

Child 3 (C3) was described by her mother as insecure, and as a girl who can be easily knocked emotionally. She worried about 'school stuff' and was shy around adults. She tended to rely on frequent re-assurance from her mother. Based on her scores, on the screening instruments and discussions with her teacher and parents, she was judged to show a mild level of anxiety.

Instrumentation

I used a research diary to record my field notes in relation to helpful and unhelpful practice actions, and to emerging intervention trends in children's engagement and to support my critical reflection. I followed a cycle of actions as per Figure 3.1 above during Phases 2 and 4 when I participated in the TG. The recommended delivery sequence of the FFL programme content was followed and can be viewed in Appendix 5.

The planning element at Stage 1 of the PAR/CGT cycle refers to the session by session preparation of each FFL session script and materials designed for the anxious intervention children. The FFL programme scripts and materials used initially required little or no verbal output from the children (e.g. Talking Mats activities). The topics chosen to illicit initial engagement were grounded in the children's own interests (e.g. food, school). They were introduced in an attempt to optimise their engagement. The PRECISE principles (c.f. Figure 2.2) and the SOC model (c.f. Figure 2.3) guided my programme delivery practice at the Co-Act stage (i.e. Stage 2). An example of a complete FFL Session is provided in Appendix 6 (i.e. *FRIENDS* Club Session 2). An example of a modified- activity (e.g. Activity 1, in Session 1) can be seen in Table 3.4.

Table 3.4 An example of a modified-activity

Session 1: Feelings	**Activity**	**Script**	**PRECISE principle**	**Details**
A 1: **Working together on the floor using large TM** Aims: To introduce Talking Mats To get to know each other To establish ways of working together to ensure we have fun and feel good.	**Using large Group Talking Mat** **10 mins.**	*First we are going to work in a group in the FRIENDS Club. To begin we can use our Group Talking Mat to show each other what foods we like.* Topic box....., Visual scale..... Options.... *You need to get your food cards ready now and I will ask:* *How do you feel about _____?* *You then need to place your card on the Mat according to how you feel about the particular food.* I see that we all made some different choices.	**Partnership** **Creative** **Investigation and experimentation**	Each child places a food on the visual scale depending on how they respond to the prompt: How do you feel about _____?

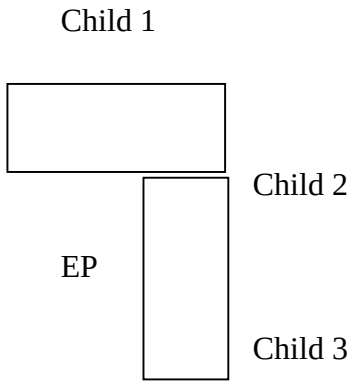
The Co-Act element of the PAR/CGT cycle refers to the implementation actions by the EP during the nine sessions with the TG. Typically each session proceeded through the recommended sequence of setting the session agenda, doing warm-up activities (e.g. Appendix 7 using My Happy Card), reviewing the previous session, delivering core programme content through the tailored activities, warm down activities and home activities.

After each session, and at Stage 4 of the PAR/CGT cycle, I had a 20-30 minute reflective discussion with the LST who was present in the learning-support room throughout. The LST's field notes, children's outputs (e.g. symbol selections, verbal utterances, observed non-verbal reactions) and my field notes were removed from the LST room after each session and used as data for analysis in the planning for the subsequent session.

Setting for intervention

When the TG children entered the intervention room, they sat in a group of three at two rectangular desks configured in an 'L' shape to allow for greater interaction between participants. I sat at the intersection of the two desks so as to enable interaction with the whole group, or in a pairing with one of the participants. A representation of the seating arrangement for participants can be seen in Figure 3.2.

Figure 3.2 Seating arrangements for programme delivery



The room layout was that of a typical learning support room approximately six metres long and four metres wide. It contained a small number of student desks and chairs, a teacher's desk, shelving and attractive wall-mounted posters. Free floor-space was available where soft floor mats were placed when needed, or where children could move freely. During intervention sessions with the TG the school's LST sat at her desk in the room adjacent to me. Her role was to discretely observe, make field notes and to administer the Talking Mats Effectiveness Coding Framework (c.f. Appendix 8) when needed. Her role in reading the children's non-verbal communication such as their smiling, what they paid attention to, their eye-contact and interactions with me and each other for example provided data which in part compensated for their infrequent use of speech.

The role of the learning support teacher in observing during the intervention

In critically searching for significance in findings, researchers need to '*keep and look back over brief but vivid accounts of incidents'* in order *'to find structure and pattern',* which leads into further and more precise questioning (Mason 2002:247).

The learning support teacher was a familiar adult in the school environment for all of the participant children. It should be noted that this was the observing teacher's normal place of work within the school as a learning support teacher. For her work in this study, she was given a hard covered note pad to record her observations. Minimal instructions were provided to her about what to focus on. She was, however, asked to maintain a discrete presence within the room, as best she could. She was asked to avoid unnecessary interactions with the children, beyond initial greetings and saying goodbye when they were ready to leave

the room. In order to discern any likely discomfort for the intervention children, her presence was discussed with the participating children in advance, when children's assent to participate was being sought using the following script:

> *Adrian has told me that Ms. _____will also sit in the room when we are doing our activities and that she will write stuff down about how the programme is working.*

No further detail about her role was provided to the children. She wrote her observations into the note pad provided. They generally contained 500-600 words of continuous prose.

Mason (2002) suggests, that in using disciplined noticing practitioners need to be cautious not to get '*caught up in solipsistic activity, spinning fantasies about, for example, how sensitive and decisive I am; I need to be validating my noticing against the experience of colleagues'* (Mason, 2002:61). I was aware that observations by others may effect changes in behaviour of both the individuals being observed (i.e. observer reactivity) and in the individuals making the observations (observer-mediator reactivity) (Hay *et al.*, 1977). Participant observation has been criticised for '*a perceived lack of validity in being vulnerable to researcher subjectivity' so* what becomes important is '*the formation of mutual understanding of the social objects between the researcher and the observer'* (Cocks, 2008:174). Charmaz (2014:36) asked: 'What should an ethnographer study in the field?' and posited that they should remain open to the setting, its members, and their individual and collective actions. They should have the opportunity to '*work from the ground up and to pursue whatever they find to be of the greatest interest'.* Discussions were held, therefore, after every intervention session with her. This action was also necessary to monitor the care and safety of the participants and this was indicated in the agreed '*Care and safety review protocols for the 'FRIENDS Club'* with other members of the project team (Appendix 13).

Data collection

In order to develop, professionals must be *'atuned to fresh possibilities when they are needed and to be alert to such a need through awareness of what is happening at any given time.'* (Mason, 2002:1).

Data were collected from a number of sources as outlined in Table 3.5 below. A key component of data collection in CGT was the constant writing of '*informal analytic notes'*

(i.e. memos) in my research diary. These facilitated the capturing of thoughts in order to '*make comparisons and connections and to crystallise questions and directions'* to pursue (Charmaz, 2006:2). Verbal, written and observational data about the symbols selected by the children, their interactions using TM, the teacher and parent comments and written parent and teacher feedback comments were collected. Data collection and analysis were simultaneous during the intervention sessions in that within sessions I needed to adjust the activity when the children's engagement dropped.

In planning Session 1, my disciplinary perspective as an EP and knowledge of the children, as provided by the class teacher, provided '*sensitising concepts'* (Charmaz, 2006: 17), or tentative ideas to open my engagement. If the planned activity or modality of delivery proved unhelpful, and the children were deemed not to engage because of its design or the delivery approach, it was discontinued. Activities which enhanced engagement were retained. In Session 1 the sensitising concepts selected were 'My Happy Thing This Week' (Activity 2) Food (Activity 3), and Likes and Dislikes about School (Activity 4). The emerging data which informed the fit between my actions and the engagement of the children were analysed after each session.

In order to use the TM approach a set of symbols on cards (c.f. Appendix 9 Symbol/emoticon cards) to represent concepts contained in the *FRIENDS* programme and the participants' interests (e.g. happiness, sadness, hurt, relaxing, brave, working together, daily events like walking, playing football, a dog, a cat) had been sourced from 'Boardmaker' (Software source of symbols used in TM). These symbol cards were piloted with a group of ten year olds in another school to determine their validity (i.e. What does this picture/symbol mean to you?). All sources of data can be viewed in Table 3.5.

Table 3.5 Sources of data.

Research Questions	Data Source		Details
	Data collection method	Sampling	
1,2	Researcher's and LST's observations Children's non-verbal and verbal outputs Children's writing on My Happy Cards (MHCs) Symbols selected during activity with Talking Mats Stories written and illustrations by children. Photos taken of participants' placed symbols/pictures Memos	Children	Written during each intervention sessions
1,2,3.	Interviews with teachers and parents Memos	Teachers and parents	Pre and post using CGT methods
1,2,3.	EP's and LST's field notes		
3	Spence Children's Anxiety Scale Behavioural Assessment System for Children-2	Children	At three points Pre (T1), post (T2) and three months later (T3)
1, 2, 3.	Unstructured interviews and telephone conversations Memos	Teachers and Parents	Before and after intervention.
2	Talking Mats Effectiveness Coding Framework My Happy Cards	Children	Administered by observer
1,2,3.	Survey of *FRIENDS* CLUB activities	Children in TG	Likert Scale

Analysis of data from intervention sessions with target group

Data from the intervention sessions comprising the LST's field notes, my own field notes and the children's verbal and non-verbal outputs (i.e. writings, picture/symbol selections, drawings) were analysed after each session. Findings from this process were used in planning for the subsequent TG intervention session. Some theoretical sampling was possible in the analysis of the interviews with parents and teachers. Charmaz (2006:89) proposed that researchers should question themselves as to *w*hat the data suggest, from whose point of view, and to what theoretical category the data relate? The analysis began

from the participants' perspective and involved line-by-line, incident-by-incident, word-by-word and in this case, comparisons of selected symbols and other non-verbal outputs as data emerged to create initial codes. Charmaz (2014) advises that using gerunds in coding is a heuristic device to bring the researchers into the data, to find implicit meanings and to give the researcher lines to explore (A gerund is a noun, made from a verb by adding 'ing' e.g. If 'read' is the verb, the gerund is 'reading'). Therefore, many of the initial codes assigned in the first round coding were words ending in 'ing'. The overall aim in using gerunds was to 'ground' the emerging data in the codes. Charmaz (2014:120) argues that we gain a strong sense of '*action and sequence*' using gerunds, and that they help researchers to detect processes and adhere to the emerging data closely.

A two pronged, open-ended and practice-referenced approach, was used in manually coding the children's outputs. This process is illustrated in Appendix 18 (i.e. *Data analysis process*). Firstly, as this is inductive research, data in relation to children's outputs were manually analysed and coded using an open-ended and flexible approach to the assignment of the initial codes (i.e. Stage 1 as indicated in Figure x below). Analytic strategies, underpinned by the two processes of comparison and questioning, as outlined by Strauss and Corbin (2008), guided this process. The strategy involves thinking about the language and metaphor used, the alternative meanings, flip-flopping the concept by looking for its reverse and exploring the emotions that are expressed in the situations.

Secondly, and in order to more closely guide my professional practice actions, the emerging data for the sessions were referenced to the PRECISE principles (c.f. Figure 2.2) and Prochaska's Stages of Change (SOC) model (c.f. Figure 2.3) at the subsequent focused coding stage (i.e. Stage 2 in Figure x below). This dual strategy was deemed necessary in order to remain as close as possible to emerging directions in the data, and in order to inform critical reflection about helpful and unhelpful EP practices for the anxious children, from session to session.

Figure 3.3. Sequence of data analysis

An example of these coding strategies is now provided. In this initial coding stage the data were given an identifier according to who recorded the data and when (R20.9=The twentieth datum from intervention session 9; O4.4=Fourth datum provided by Observer i.e. LST). An example of this coding process which took place (i.e. Figure 3.1) can be seen in Table 3.6.

Table 3.6 Example of coding

1.		**2.**		**3.**		
Initial codes (gerunds in bold)	**Source**	**2nd Round focused code (c.f. Appendix 10)**	**P or S O C**	**3rd Round Categories (c.f. Table 4.1)**	**Research question**	**Helpful(H) Unhelpful (U) Unclear (?)**
P1 and P 3 **being** very stiff during RTJ relaxation exercises	O4.4	Children's participation(CP)	P	Child	2.1	U
Participants **enjoying** guessing game	O2.1	Children's participation(CP)	P		1.1	H
Do they understand what a personal goal is?	R20.9	Researcher Reflection (RR)	P	Research process	3.2	?
Building more feeling recognition	D1.2	Research Process (RP)			3.2	?
P1 Not *locating* worry in her body	R17.2	Children's Perception of Programme (CPP)	S O C		1.1	U
The TM symbols were topical and clear for girls	O12.1	Right developmental level (R)	P	Therapeutic relationship	2.1	H

Analysis of these initial codes, to determine what was helpful and unhelpful then focused on data that occurred frequently. Judgement in relation to helpfulness was based on my analysis of the children's engagement with FFL concepts, as introduced through my actions with materials and with each other. The LST's judgements on what was helpful were captured in the comments like '*Child x laughed when...; child x looked interested when...).* Unhelpfulness was frequently described as '*Child x looked bothered by...*; *child x had a furrowed brow when...).*

As the participants engaged in the programme, the emerging data were rich and varied. During sessions 1-9 the number of focused codes increased significantly (c.f. Appendix 10

Second round focused codes). A greater level of abstraction took place as the sessions progressed with the analysis being underpinned by memo-writing. The memos helped me to capture my thoughts and sense the directions to follow, from session to session, in relation to emerging concepts (Charmaz, 2014). Memo-writing frequently occurred immediately after each session and created a space for interacting with self about the emerging data in relation to my research and practice. The following extract from my diary provides an insight into this process:

> *Memo: Children's participation: At this stage I feel it is useful to get closer to real life specific worries that could be used as a basis for discussion about helpful and unhelpful thoughts. I am trying to make this more safe, check for readiness and engage in some formulation. This does not happen in FRIENDS at a whole class level and has a clinician/therapy feel about it but also is respectful of the rights of the child and the need for group cohesion (i.e. working towards achievement of goals). I need to consider levels of engagement and to explore whether there is a group indicator for this which can help us move forward together. I need to check their motivation. Perhaps I can use some sort of group readiness scale, with the slips of paper when they have written their worries on them.*

Study categories and concepts

Fifty eight focused codes, at Stage 2 of the data analysis process, were chosen on their ability to subsume the most significant and relevant initial codes into clusters. This enabled the examination of larger batches of data. In CGT is understood to involve pre-existing, interactive emergent conditions between participants (Charmaz, 2014). The codes selected were influenced by my values, perspectives, privileges, positions and geographical location. This focused coding, thus, was not a neutral act.

The approach meant learning '*how, when and to what extent the studied experience is embedded in the larger and often hidden structures, network, situations and relationships'* (Charmaz, 2014:240). Through memo-writing, relationships were traced which were founded in the events of all sessions with the participants. Fifty eight second round codes were identified and defined (c.f. Appendix 10 *Second round focused codes and definitions).* These codes were deemed to have carrying capacity specific to this study.

Some coded data were omitted due to their lack of relevance to the overall study aims. Significant reduction in TG data was also possible through merging focused codes, which

showed theoretical connectivity, under categories which bore more direct relevance to the study.

The fifty eight codes at Stage 2 were subsequently reduced to the study's ten categories (i.e. Stage 3, Figure 3.3). This process involved an examination of the analytic strength of each category to carry the grounded data from the initial code through focused coding to a coherent theme that fitted the data.

The Stage 3 categories show a greater level of abstraction (c.f. Table 4.1 and Appendix 14). The categories selected to subsume the emerging focused codes were broad (e.g. Ethical, Child, Anxiety, School) and were themes which accounted for the emerging data in the context of the intervention and the participants interactions.

Stage 4 of the data analysis involved the identification of the study's three concepts. These are the most abstract labels used to account for the relationships defined in the empirical data with each concept being traceable back to its empirical indicators (i.e. Stage 1 in Figure 3.3). The concepts were chosen because of their theoretical reach, incisiveness and generic power (Charmaz, 2006). An example of this process can be seen in Table 3.7.

Table 3.7 Focused coding to conceptual level

2rd round focused codes (58)	**Research question**	**Categories (10)**	**Study Concept**
Children's participation(CP)	2.1	Child	Application
Children's participation(CP)	1.1		
Normalising (N)	3.2	Ethical	
Partnership (P)	3.4	Therapeutic alliance	

The final stage of analysis involved the synthesis of concepts which could integrate, into a theoretically coherent framework, the relationships between the clustered data as represented by the ten themes. The development of the framework for the concepts, (i.e. the study's proposed conceptual framework for EP practice, seen in Chapter 6) involved moving from the analytical process described above in data analysis, to the examination of the relationships between the emerging study concepts and how they could deepen the understanding of these relationships. In this interpretivist study, the theoretical framework

presented in Chapter 6, represents the researcher's imaginative, subjective, understanding of the studied phenomena in terms of '*practices and actions'* for an EP (Charmaz, 2014:231). This process drew on Bronfenbrenner's (1979) Ecological Systems Theory, also, which describes human behaviour as arising in the context of complex interactions between the characteristics of individuals and the environments in which they interact, a theory which aligns with the NEPS model of service.

Analysis of interview data

Constructivist interviewing practices were used with parents and teachers. The interaction with the interviewee was used as a basis for '*exploration, emergent understanding, legitimation of identity and validation of experience'* (Charmaz, 2014:91). The approach used placed emphasis on the creation on an interactional climate which encouraged the participant to talk by being gently guided towards an exploration of their experience from their vantage point.

As the interviewer I gave initial direction, but the semi-structured and emergent nature of the exchange quickly shifted control to the participant. This approach was suitable for a number of reasons. Firstly, given that parents of anxious children may well be anxious themselves, and that studying '*stigmatised behaviours may raise questions of being intrusive'*, the use of an open-ended, non-judgemental approach was considered more sensitive (Charmaz, 2014:65). Secondly, the approach allowed the EP to draw on many years of professional experience interviewing parents of children with complex needs. An advice sheet was compiled to guide EP practice in *'Doing an Intensive Interview'* and is contained in Appendix 11. The interviews took place in the school. Interviews were digitally recorded and subsequently transcribed and coded.

The coding process for the interview and intervention sessions data was the same except that some limited theoretical sampling was used as a tool in the latter. In this process the researcher used the focused codes emerging from the first round of interviews as a basis for memo-writing. The provisional categories which emerged from this process were used subsequently within post-interview discussions in order to follow the researcher's hunches and to *'illuminate'* and develop categories of meaning further (Charmaz, 2006:103). This was strategic and used in pursuit of data for deeper analysis on categories which had already been identified (e.g. Teacher as advocate). One round of theoretical sampling was deemed adequate in the research context where the intervention had been completed and further

contact with parents by the EP may have gained negative attention within the school community. The EP was conscious of the *'lines between involvement and distance in field research',* and that continual renegotiation may have been counter-productive with parents of anxious children (Charmaz, 2014:209).

Research Quality

It can be argued that this qualitative approach, where the researcher was a participant, will never be scientifically replicable and hence be of low value to other schools. A pragmatic approach therefore was used which was respectful of scientific aims for replicability but which drew on '*post scientific conceptions of social research'* (Seale *et al*., 1999:24). Concepts such as transferability, or its potential use by EPs in other schools, dependability or its potential use at another time, and confirmability, which considered whether the author has managed not to overtly allow personal values or theoretical inclinations to sway the conduct of the research and its findings, were crucial. Lincoln and Guba, (1985) argue, that the two strategies of thick description in the research narrative and the use of purposeful sampling, increase replicability and allow others to judge whether the findings of a particular inquiry may have applicability in other contexts.

In terms of this study's credibility (i.e. validity), the data were grounded extensively in lengthy fieldwork carried out over an eleven month period in 2014. Contrasting data sources supported triangulation which is a major component in seeking confirmability. I have drawn on Charmaz's *'Criteria for Grounded Theory Studies'* (Charmaz, 2014:337) under the headings of 'Credibility','Originality', 'Resonance' and 'Usefulness' to reflexively comment on the quality of this research in the final chapter (c.f. Table 6.2).

Reflexivity

In discussing my position as researcher and participant in the process of analysing qualitative data, Denscombe (2010:302) points out, that while '*the researcher's identity, values and beliefs cannot be entirely eliminated',* there is a growing acceptance that the provision of some biographical details can help to explain how personal experiences and values might influence matters. In this regard, a biography is provided in Chapter 1 and a reflexive account in Chapter 6. I was an '*insider*' researching an aspect of childhood relevant to my own practice. Denscombe (2010:302) recommends that researchers '*should distance*

themselves from their normal, everyday beliefs' and '*come clean about the way in which their research agenda has been shaped by personal experiences and social backgrounds'*. Every attempt was made to do this.

Tashakkori and Teddlie (2003) posit that a belief that realities are socially constructed is pertinent to the field of educational psychology. My active participation, through the study's PAR/CTG model has benefits in this regard, as it enables hypotheses to be shaped and changed throughout the study thereby giving a more fluid flow to intervention processes with the children. Further, Willig, (2001) points out that the personal impact and journey of the individual researcher in qualitative research cannot be underestimated. However, through direct involvement, the experience can be professionally edifying for practising psychologists as opposed to experimental or academic psychologists by way of broadening their perspectives and professional understanding of applied practice. My reflections, therefore, later in this document, will consider the implication of this work for my school-based practices as an EP.

Ethical considerations

Anxious children could be described as vulnerable. I was acutely aware of their '*possible heightened emotions'* and of the need to collaborate with others to suitably individualise intervention programmes (Cleave, 2009:245).Strategies based in established ethical guidelines were used to guard against this risk of harm (i.e. BERA Guidelines, (2004); Psychological Society of Ireland's (PSI) Code of Ethical Conduct, (2010); NEPS Research Advisory Committee's (RAC) guidelines (2015). Ethical practice for this study complied with Article 3 of UNCRC. This article requires that the best interests of the child must be the primary consideration (c.f. Appendix 12*Ethical Approval* (Form EA2)).

A key element in guarding against risk of raising children's anxiety levels was a monitoring, through discussion, by the school-based care and safety team. The team comprised myself, the LST, the class teacher and individual parents by invitation (c.f. Appendix 13, *Care and safety review protocols for the* '*FRIENDS* Club'). The team met weekly during the course of the research.

Ethical practice is linked with the active construction of research relationships and cannot be based in presupposed ideas or stereotypes about children. Any emerging dilemmas or difficulties, that arose were managed within a dual strategy of, firstly, the application of

relevant ethical guidelines, and secondly, through the researcher's responsibility to be constantly sensitive and reflexive as a researcher

> *Ethical research with children requires that researchers adopt open communication with child participants (who may be unsure or confused about how to respond to being treated as competent social actors) and critical reflexivity toward all aspects of the research as it occurs.'* (Freeman and Mathison, 2009:70).

The care and safety review instrument (c.f. Appendix 13) was used to help execute and record the use of these two strategies. *'It is not only a question of seeing the world from children's perspectives, but of acknowledging their rights to express their point of view or to remain silent*' (Clark and Moss, 2001:7). In this regard, the children in the TG were made fully aware of their right to withdraw at any time and/or to remain silent (Hutchfeld and Coren, 2011). Consent was viewed '*as an ongoing process and not a mere one off event'* (Lambert and Glacken, 2011: 796). The British Educational Research Association (BERA) (2004) guidelines, which state that researchers must '*desist immediately from any actions, ensuing from the research process, that cause emotional or other harm',* were followed.

Chapter Summary

This research aimed to develop an understanding of the perceptions and impact of a modified intervention for three sub-clinically anxious primary school children.The chapter positioned me as an active participant in the *FRIENDS* intervention with the anxious children which was designed to flexibly accommodate the children's needs as it progressed. A participatory action research approach was integrated with a constructivist grounded theory approach in a study-specific PAR/CTG model in order to gather and analyse qualitative data within the intimate context of the target group. The ethical responsibility to care and keep safe the children was outlined as were issues in relation to researcher positionality and research quality. The following chapter presents the study's findings in relation to the three research questions posed.

Chapter 4 Findings

Introduction

This small-scale exploratory study sought to explore the perceptions, and professional practice implications, of an intervention for anxious children in a small rural primary school in the RoI. It aimed to:

- develop an understanding of the participants' perceptions (i.e. teachers', parents' and anxious children's perceptions) of the contribution of an adapted CB-based intervention (i.e. *FRIENDS for Life*) to a targeted group (N=3) of sub-clinically anxious children in primary school;
- develop an understanding of what is helpful or unhelpful in relation to reducing their anxiety,
- explore the factors which help or hinder the delivery of a targeted intervention, by an EP, to anxious children in primary school.

This chapter presents the findings in relation to the three research questions posed to fulfil the study's aims. Words typed in italics hereafter in this chapter only, and not within parentheses or speech marks, represent the focused codes which emerged from the data analysis process. They are now used to answer the research questions. A complete list of the fifty eight most significant second round focused codes, and their associated definitions used in this chapter, can be seen in Appendix 10 (i.e. *Illustration of second round codes*).

These focused codes were clustered thematically into ten themes and three study concepts (i.e. *Appendix 14 Illustration of third round themes and study concepts*) based on decisions in regard to what made analytic sense. The study's concepts relate firstly to programming for anxious children, secondly to the application of an intervention with anxious children and thirdly to the cognitive-ecological context for an intervention in a primary school. These three study concepts and their associated themes can be seen in Table 4.1 below.

Table 4.1 Study concepts

	Study concepts		
Categories (Themes)	**Programming**	**Application**	**Cognitive-ecological**
Anxiety		✓	✓
Child	✓	✓	✓
Ethical	✓	✓	✓
Family	✓	✓	✓
Therapeutic relationship (PRECISE principles)	✓	✓	
Programme delivery	✓	✓	
Research process	✓	✓	✓
Teacher	✓	✓	✓
Impact	✓		
School			✓

Study Concepts

Programming as a concept in this study refers to core content elements of the *FRIENDS* intervention (i.e. prescribed *FRIENDS* programme activities), and newly introduced activities which were perceived as helpful or unhelpful when working with the children. Helpful and unhelpful are broadly understood terms in this study which refer to factors interpreted as promoting or hindering access to the intervention programme for the children. Application, as a concept described hereafter, refers to my actions as an EP or to those of the participants (i.e. children's, teachers' and parents') in the context of this intervention and of what was helpful or unhelpful. Within this concept my actions in relation to the seven PRECISE principles are subsumed under the code *therapeutic relationship.* The concept cognitive–ecological (Guerra *et al*., 2005) emerged as relevant in this study as it refers to a multi-factor framework that emphasises the confluence of individual factors (i.e. temperament and other personal factors), environmental factors (i.e. family, neighbourhood,

and social factors) and situational factors immediate to the school context within which the programme was applied. A more detailed discussion will follow on these concepts in the next chapter in relation to targeted interventions for anxious children. What follows now for the reader is an overview of how the intervention developed and a description of the helpful and unhelpful factors. This is important due to the care needed to effect engagement with anxious children and to describe the emergent nature of the work. Data which emerged in relation to the four research questions are then presented.

Intervention overview

A flexible, five-phased approach in relation to intervention delivery emerged. As can be seen in Table 3.2 in Phases 1, 3, and 5 all children were together in their classroom. This combined group is the UGTG or universal group (i.e. all twelve children). In phases 2 and 4 the TG and UG children received the programme separately in the learning support room. Data indicate that the 'two settings approach' was a factor in *normalising* the activities for the children. Children from both groups asked their teacher if they could go '*out to do FRIENDS'* on a number of occasions, suggesting that it was accepted as a '*normal*' thing to do once the intervention began.

The interactions between the TG children and I changed significantly as the intervention progressed. During the first three sessions their utterances were frequently single word responses, followed by silence. There was also little interaction between the children themselves. This pattern of behaviour was unsurprising. After Session 4, a greater *therapeutic relationship* developed as we began to explore the use of story. The children's body language showed their increased willingness to engage (i.e. eye-contact, use of smiling) and they relied on less prompting. The *FRIENDS* programme content remained the core consistent element of each session but the emergence of story-writing became the preferred and dominant intervention methodology for *programme delivery*. Data in relation to the four research questions are now presented. (Hereafter C1 refers to child one, C2 to child two and C3 to child three).

Research question 1: Participants' perceptions of the intervention (Aim 1)

What elements of the intervention were perceived by the target group children as helpful or unhelpful?

Ideas to make the *FRIENDS* Club a success

The children's choices in relation to the ideas for making the group a success gave insight into their perceptions of how the intervention group should run. In Session 1, a number of ideas to help make the *FRIENDS* Club a success were written on cards and shared with the children. The children ordered the ideas from 1-10, where 1 was the most preferred and 10 the least preferred. C1 and C2 both selected *'We can write or say our ideas and it's OK to remain silent at times'* as their number one idea. All children rated the idea *'It is really important to have fun at some time during each session'* within their top three selections. Surprisingly, only one of the group selected '*If a person becomes uncomfortable in the group they can raise the 'I want to Stop' card and no one will make a fuss about this.* One might have expected anxious children exhibit greater discomfort in novel situations (e.g. Gerull and Rapee, 2002), and to favour strongly the creation of a withdrawal mechanism (i.e. the '*I want to Stop'* card). In line with the study's *Care and Safety* protocol (c.f. Appendix 13) this idea was added to the final list which was subsequently typed and displayed close to the children in the LST room. The list of five ideas can be seen in Table 4.2.

Table 4.2 List of ideas to make the *FRIENDS* Club a success.

1. *We can write or say our ideas and it's Ok to remain silent at times.*
2. *Everything discussed in the Club is confidential.*

(This means that a person can share their own thoughts and feelings with others but sharing what other people say is not allowed unless you have permission from that person).

3. *It is really important to have fun at some time during each session.*
4. *All group members are encouraged to take part.*
5. *If a person becomes uncomfortable they can raise the 'I want to Stop' card and no one will make a fuss about this* (c.f. Figure 4.1)

Surprisingly, no child used the '*I want to stop'* card throughout the intervention. A key limitation in using the '*I want to Stop'* card may have been that its original introduction was very much led by me. Its inclusion as a safety mechanism may need additional consideration

in light of the study's commitment to the principles and characteristics of participatory action research (McTaggart, 1989) (Appendix 19).The *FRIENDS* programme recommends the idea of writing a 'Class Contract' about behaviour within the group but this may have served to raise anxiety through increased formality. The establishment of clearly understood protocols to optimise the children's emotional comfort was challenging.

Figure 4.1 I want to STOP card

Relaxation

C1 and C3 consistently indicated through written comment that they found the breathing exercises for *relaxation*, which formed a part of every session, to be most enjoyable. C1 frequently adopted a foetal position during the relaxation activity and commented in her writing that '*I feel better after it - just like when I wake up on a Saturday morning'.* The *physical elements* (i.e. location they selected) for the relaxation seemed to be important for the children. Initially, and even when prompted to use all areas in the room, the children chose to stay at their desks for this *relaxation* exercises. The LST commented in her field notes during Session 1 that C1 '*didn't seem to be relaxed. She had her legs crossed under the chair and her hands were tightly clasped'.* In Sessions 3 and 4, however, all three children chose different individual body positions in different locations within the room. C1 chose to lie on the mat and curled up, C2 chose to recline on her chair but remain at her desk and C3 tended to move away and sit at a distance on the floor. This suggested to both the LST and I that the children were becoming increasingly more *relaxed* within the setting.

In Activity 4, Session 3, the children were encouraged to role-play '*Robots, Towers and Jellyfish'* a movement game to build awareness of a tense body (i.e. a robot) and a relaxed body (i.e. a jellyfish). Two of the children (C1 and C3) appeared very self-conscious during

the activity and tended to remain stiff in their actions even when attempting to play a character. The difference between how they looked while role-playing robots (i.e. tense body) and role-playing jellyfish (i.e. relaxed body) characters was not very noticeable. Overall the response to the relaxation exercises in the *FRIENDS* programme indicated variable engagement by the children.

In an effort to support all children in the use of this relaxation element of the intervention a variety of peaceful images from nature, carried on a series of postcard size pictures were offered throughout the initial sessions. These were used to explore their ability to use *visualisation*. It was noted that children consistently selected image 1 of field and sky shown below in Figure 4.2 to use in their personal relaxation time during the sessions.

Figure 4.2 Image of field and sky.

The Millie Stories

In Session 3, C2 unexpectedly brought a new book she had received as a gift and all children became extremely interested as I read a passage from the book. The *children's participation* increased noticeably when I offered to read from the book. The observer noted that they were '*straining and standing up'* to gain a view of the material being read. C2 shared the book

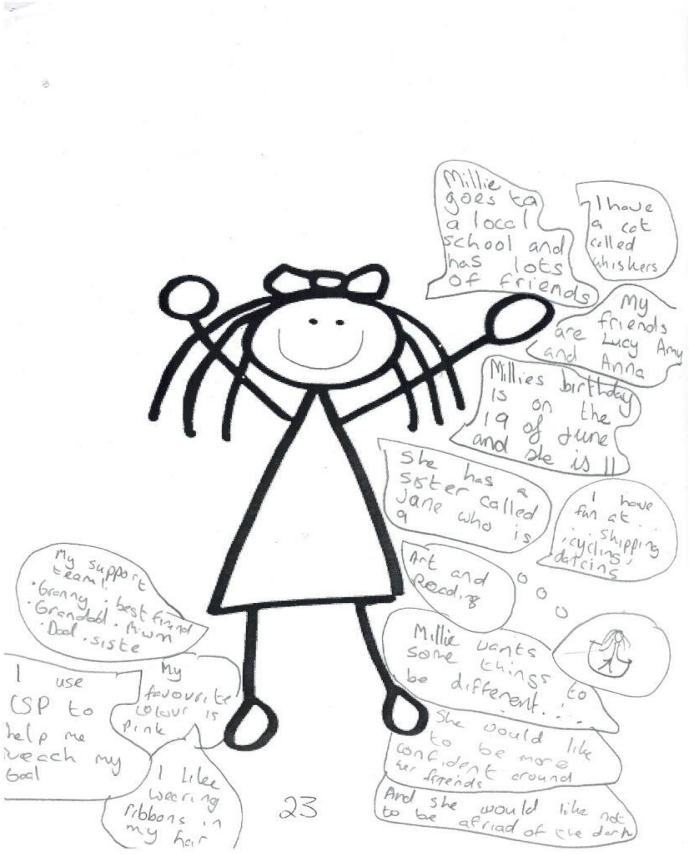
with the others who leafed through it and smiled at the illustrations and its overall quality. This was interpreted as a significant increase in children's participation. Interestingly, the introduction of the book was not my suggestion. It was un-signalled action by C2. The children's reaction to this book-based activity was interpreted as a positive and authentic example of voluntary participation.

Based on this positive development, I introduced a story '*When My Worries Get Too Big*'. The story's main character, Mike, managed to reduce his worries about getting on a bus on a scale of 1-5, from a 5 down to a 1. When I began to read the story the observer noted that C1 was '*very interested'* in Mike's story and that C3 '*needed to hear the full Mike story'* and that the children were '*straining and standing up to see the book'*. This represented a notable increase in *children's participation* and led to the introduction of story writing as a key programme delivery element in subsequent sessions.

In Session 4, and based on the process of constant comparison contained in Stage 3 of the PAR/CTG model, I subsequently introduced three stick drawings of girls for the purpose of selecting a character on which to base their own stories during the subsequent intervention sessions and crucially to carry the *FRIENDS* content. The children selected one particular stick drawing of a girl seen below in Figure 4.3 and named her Millie. The whole group then wrote stories with my assistance. The stories became known as the 'Millie Stories' to the group. Children coloured their own Millie character's clothes, used speech and thought bubbles to convey ideas and frequently changed the expression on Millie's face to help show her different emotions as seen in Figure 4.3.

An interesting aspect of this work with the children was that at times they linked the story they were completing directly with Millie (e.g. *'Millie's birthday is on the 19th of June and she is 11'*) while at other times they adopted the persona of the character (e.g. '*I like to wear ribbons on my hair'*).

Figure 4.3 The Millie character



Millie goes to a local school

I have a cat called Whiskers

I like wearing ribbons on my hair

Millie's birthday is on the 19th of June

My friends are Lucy, Amy and Anna

She has a sister called Jane who is 9

Millie wants some things to be different

I read a Millie Story to the children carrying core session content at each subsequent session. The girls then began to write their own Millie Stories during sessions which focused on how Millie managed to do a number of activities related to her wellbeing (e.g. Appendix 15*Millie's small steps plan*). The stories contained core *FRIENDS* content including how she scaled her worries (i.e. Story 1), developed a Coping Step Plan (i.e. Story 2 where Coping Step Plans were renamed as Short Step Plan), and used a Five Block Problem Solving Plan in Story 3.

The observer noted in Session 5 that the children's participation, using this Millie story writing process as the main modality of content delivery, increased the *children's participation* and noted in her field notes that *'all children are actively writing and colouring their stories'.* She noted also that C3 '*voluntarily spoke for the first time'* (*Verbal output*) and that C2 and C3 were '*chatting freely'* during the work on feelings recognition. C1's parent commented that her daughter '*likes doing the stories' (Enjoyable).*

It was interesting to note also that C1 integrated content from the story in Session 4 in regard to scaling (i.e. reaching a 1 or a 2 on the worry scale) and *FRIENDS* skills learned in earlier sessions (i.e. breathing and visualising their favourite places). C3 associated her worries when they were at 5 on the scale with the colour red which shows alignment with *FRIENDS* content, and suggesting that programme delivery was being perceived as helpful by the children by virtue of its application within their Millie Story. Examples from the children's work can be seen in Figure 4.4.

Figure 4.4 Examples of children's work on Millie Stories.

An interesting observation made by the LST was that the children all began to physically conceal their writing and drawing as they worked by hiding it using their hands and arms. Perhaps this represented a signalling that their own worries are confidential. Based on the

LST's feedback, my interpretation of the emerging pattern in relation to children's participation and feedback from one parent, the story writing by the children was regarded as their preferred method for programme delivery, and therefore, core *FRIENDS programme* concepts such as the Coping Step Plans and the Five Block Problem Solving Plans were subsequently delivered through the Millie Stories.

Data from the children's writing in the Millie Stories also indicate the emergence of helpful *investigation and experimentation* by the children in Phase 4 sessions when they selected a personal goal or challenge to explore from a wider range of topics not specifically related to school (e.g. not being able to swim, scary things, and friendship). As seen in Figure 4.5, C1 chose to set *'being shy around unknown adults'* as a goal.

Figure 4.5 Child one's goal

The following script produced by C3 also illustrates this finding:

Red thought: *I accidentally hurt my friend at GAA* (i.e. football practice) *and now she won't talk to me.'*

Challenger Question: *What could be a more powerful thought?*

Green thought: I have other friends and it doesn't matter what she thinks of me.

Content analysis of the Millie Stories shows that the children began to use some language relating to *programme concepts* introduced to them in earlier sessions. Given that C1 was identified as the child who interacted least with her peers at school, it is interesting that she set as a goal and chose action words in relation to social interaction and problem solving in her story.C2 chose a school related goal (‘*Ask the teacher to explain the* (Blank) *again’*) and drew up a four step plan based on breathing (Step 1), practice asking (Step 2), ask (Step 3) and ask (Step 4).

Children’s participation in the group

Data in relation to *children’s participation* suggest that they each perceived the impact of being in the small group for part of the school day differently at the start. C1’s writing shows her concern about missing out on school work. C3’s mother indicated that her daughter was concerned about missing her friends

> *Yes well you know her friends were in the big group and she couldn’t understand why and this really got her antennae up and she was really suspicious.*

When the two groups were merged after Session 5, C3’s mother commented that her hunch was that her daughter realised that both the target and universal groups were involved in a similar type of learning. As she suspected earlier, it was the separation from her friends that had mattered most to her initially and that ‘*when she joined the big group then she realised this is not a big party...it was the exclusion’.*

Data indicate the children continued to focus on *school related anxiety,* particularly during the early sessions. Their writing and picture selection outputs on TM show a common theme relating to school performance in maths and homework. They frequently chose these topics when selecting challenging and unhelpful (i.e. Red) thoughts to change to more helpful thoughts. The image taken from C3’s Millie Story, and seen in Figure 4.6, was interpreted as showing her worry in relation to the volume of her written output by comparison with her peers. C3’s drawing shows Millie’s two sheets of paper. One has three lines of writing on it and is headed ‘*Me’* while the other sheet is full of writing and is headed ‘*Everyone else’*

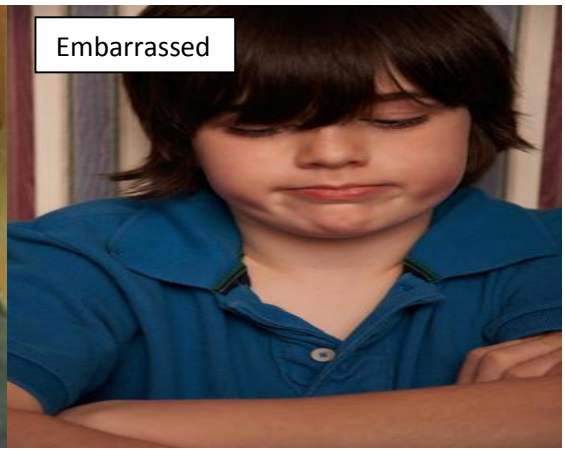
Figure 4.6 Drawing by child three (C3) in relation to her production of writing

Programme concepts

The *FRIENDS* programme emphasises helping children to recognise their feelings as a first step in normalisation and anxiety reduction. Data in relation to feelings recognition from this study and coded as *programme concepts,* show that the children experienced difficulty early on in the intervention accurately recognizing feelings represented by images on cards (hereafter called feelings cards) showing various facial expressions accompanied by descriptions of real life situations children experience.

While children frequently identified images on cards representing people being relaxed, happy, sad and confident, the selected images showing people looking curious, brave, anxious and embarrassed proved more difficult. The four feelings represented in the images in Figure 4.7 proved difficult for the children to successfully identify and role play non-verbally with each other.

Figure 4.7 Images of difficult to identify feelings



The children's speed at recognising and role-playing the feelings non-verbally (Activity 3, Session 2 *FRIENDS*) when using the cards, was perceived as slow. The LST and I viewed this as increased anxiety (i.e. *anxiety identification*). The LST noted, for example, that during this activity C3 was '*watching and not joining in'* in Session 2 when the guessing the feeling game was underway. The activity progresses to a situation where children stand up and act out feelings in pairs. However, the children did this activity while remaining in their seats as the LST had noticed, and commented on their increased signs of *anxiety* in C1 ('*dropped her head'*) and C3 ('*hunched her shoulders'*) when their turn to stand up and act out a feeling arose. Data show that their ability to role play improved as they gained familiarity with the images of the feelings.

The LST noted that C1 began to '*raise her hand'* during this activity in Session 3. This activity to develop their ability in this aspect of the programme, which is a major learning

outcome for Session 2 of the FFL programme, was continued in Sessions 3 and 4. The children slowly became more familiar with the task. They gained some confidence in non-verbal performance. I frequently exaggerated some of the feelings for effect to make it more fun for the children (e.g. being overly curious or overly sad). C2 showed the most enthusiasm for this game. She smiled and positively and oriented her body towards me during role-play. This may also have helped C1 and C3's participation. This activity therefore was interpreted as *enjoyable* for the participants by both the observer and I.

***FRIENDS* programme workbook**

The use of the *FRIENDS* workbook is a recommended element of the *FFL programme.* During sessions 1 and 2, its use led to periods of sustained silence where the children appeared to write little. The LST noted that its use '*caused the group atmosphere to drop'*, while I noted in my field notes that '*the workbook impacts the dynamic too much'.* While some activities from the workbook were completed, there was noticeably greater *partnership* in sessions when programme materials were prepared by all together as the opportunities arose (e.g. drawing an outline of a body on which to draw body clues for session 3; cutting out red and green blank cards on which to write their thoughts in session 5).

The use of a workbook in the delivery the programme is interesting in light of comment from the recent evaluation by NEPS (2014:64) of *FRIENDS* which stated that '*teachers stuck too rigidly to the children's workbook, which was not always culturally or age appropriate'*. Given that the children had selected as one of their ideas to make the *FRIENDS* Club a success that '*It is really important to have fun at some time during each session'* they may have perceived this element to be counter to this idea. They may also have felt daunted by the volume of material in the workbook. One priority during Phase 2 was to encourage comfortable participation in activities, interact with one another and build group cohesion. The workbook offered little in regard to these objectives and so its use was discontinued within the TG after Session 2.

Stages of Change (SOC)

In Session 4, and in the context of exploring unhelpful thoughts, intervention focused partly on incorporating the first two steps of the SOC framework (Prochaska *et al.*,1992, Figure 2.3), the pre-contemplation and contemplation stages. This is a framework which allows for an extension to programme content in relation to facing something difficult (Barrett, 2012:80). At the first of these stages the intervention aimed to help the participant identify discrepancy between their current situation and what they would like to achieve.

'*Understanding the child's readiness to change and where they are in the cycle can help to determine the type and main focus of the intervention'* (Stallard, 2005:10). An insight into my actions at this stage of the PAR/CTG based intervention process can be gained from the notes on my script from Session 4 which read

> *At this stage I feel it is useful to get closer to real life specific worries that could be used as a basis for the helpful and unhelpful thought discussion. I am trying to make this more safe, check for readiness and engage in some formulation. This does not happen in FRIENDS at a whole class level and has a clinician/therapy feel about it ... but also is respectful of the rights of the child and the need for group cohesion (i.e. working towards achievement of goals). I need to consider levels of engagement and to explore whether there is a group indicator for this which can help us move together. I need to check their motivation. Perhaps I can use some sort of group readiness scale ...with the slips of paper when they have written their worries on them. (This is from Stallard's approach page 11; allow for non-verbal participation; allow for confidentiality; try to elicit group consensus).*

In an attempt to probe the children's unhelpful thoughts, I modelled a response to the question contained in a Millie Story '*Is there anything at home or at school that I would like to be different?* and shared my unhelpful thought and solution with the group: '*I am worried that I will make a mess of a talk I am due to give at the local school and don't really want to do it. I could take an hour off work tomorrow and practise my talk with my colleague at work'*. This modelling may have prompted C1 to subsequently write in her story that her greatest worry is being '*unsure about the next day',*C2 wrote that hers is about *' thinking bad thauts'*(thoughts) and C3 indicated that hers related to *'doing a test'.*

At the second stage of the SOC (i.e. contemplation), which aims to analyse potential obstacles and sources of help, C1 also wrote that '*it is possible to tackle that worry'* and that she could find out about the next day in advance. C2 chose to name family members as sources of help and C3 wrote '*I could take my mind off it'.* These writings contained the personal anxieties of the children. In respect of C1 and C2 they were interpreted by the LST, who is familiar with the children's behaviours, as representing their anxieties (i.e. C1's need for structure and predictability, C3's anxiety in tests). Stallard, (2005), guides that a potential therapeutic pitfall is the therapist's natural tendency to '*work hard to convince or persuade the child that change is needed and is indeed possible'.* This was not considered appropriate within the group setting. It is important to state that the unhelpful thoughts were not shared within the group. I subsequently noted in my research diary during a PAR/CTG Stage 4 reflection

Writing my own Millie Story to carry the stages of change framework was an attempt at deepening the usefulness of the intervention for the children in the target group. Writing the Millie Story also gave me a tool to bring to the surface some personal information about normal worries in my own life (i.e. making a mess of a public lecture). I also had the chance to model how I could deal with the challenge. This was the first time I feel I had a chance to facilitate their own reflection on their challenges.

I need to be mindful however that what I am engaged in is not therapy. This is not a clinical situation. This is a skills focused support intervention. I am however well positioned now. A key safety element lies in the comfortable pitching of the task. Story allows them to write it or not. There is hopefully no pressure on them. Using PRECISE principles to get to this point was so important. I hope they can use the ideas they have written later on when we begin to set goals.

Survey of *FRIENDS* CLUB activities

A post-intervention survey (Likert Scale), where children were asked to rate all the activities from 5 (Really liked the activity) to 1 (Really didn't like the activity), was carried out with the TG children. Overall, twenty four intervention activities were rated by the children through their completion of the *intervention* (c.f. Appendix 16*FRIENDS Club activities*). The activities they liked most, received a maximum of fifteen survey points, and included relaxation on the mat, selecting pictures for relaxation, using the MHCs and learning to use the challenger questions. Learning about how Mike managed his worries, writing the Millie Stories and doing the *FRIENDS*TV show were rated next and assigned fourteen survey points. The children's preferences in this survey can be seen in Appendix 16.

This concludes the presentation of findings in relation to research question one which described the children's perceptions of how to make the programme a success, their experience of various modified *FRIENDS* programme activities and its workbook, and their ultimate choice to write Millie Stories as a way of interfacing with the *FRIENDS* content. It also described my use of reflection within the study's PAR/CTG model. Findings in relation to research question two will now be presented.

Research question 2: Children' perceptions of mode of response (i.e. verbal or non-verbal) during the intervention (Aim 1)

Research question 2.1: What did the target group children perceive to be helpful or unhelpful when the intervention response mode was predominantly non-verbal?

My Happy Thing This Week cards (MHCs)

At each session the children were provided with plastic, post-card sized, cards on which to write or draw a happy event from their recent lives with a dry-erase marker (c.f. Figure 4.8). This card became known as their 'My Happy Card' (MHC). Data show that at the beginning of the first two sessions the *children's participation* was enhanced when I guessed what the children had drawn on their cards. They only needed to nod or utter one or two words in response to my guess (e.g. *It looks like you are happy playing with your dog in the picture*?). Occasionally, I made my guesses deliberately humorous and improbable. This served to get the session off to a positive and fun start. Crucially there was little requirement for participants' full verbal communication. This approach became an integral element of all subsequent sessions. The children drew pictures about happy events in their family lives including the arrival of grandparents on a visit (C1, c.f. figure 4.8), horses (C2) and learning to play the guitar (C3). This process served to meet a key *FFL programme* requirement of helping each other to work together while having fun. The observer noted that the children were '*quiet but engaged'* when responding to my guesses. C1 tended to nod yes or no as a response.

Figure 4.8 My Happy Card (MHC)

As the sessions progressed the participants worked in pairs and themselves became the guessers. They appeared excited to share their drawings of personal events (e.g. getting a

new pair of shoes). The LST and I perceived this as offering opportunity for *enjoyable* activity to the children. Initially their attention was drawn as a group to my MHC card while I suggested what my drawing contained and they only needed to nod 'yes' or 'no' if they agreed with my suggestion. The observer noted that all three '*looked engaged'* and were '*smiling at the activity'*.

This fun activity allowed me to reflect participants' emotions (e.g. their agreement, rejection or neutral response) back to them which may have helped participants to *'clarify their own feelings and indicate that they have been heard correctly'* (Ivey, 1994, cited in Barrett, 2012:18).This approach aligned well with programme guidance to use a variety of activities to suit the anxious children. It also helped to establish a working together process and may have helped the children realise that I was willing to play and have fun which is a *FRIENDS* objective and a key factor in managing the power differential, as mentioned earlier in Chapter 3.

Talking Mats (TM)

During Session 1 the children used TM (c.f. figure 4.9) twice in order to facilitate their non-verbal participation, and to carry the programme element in relation to similarities and differences. The three children and I initially sat on the floor and used a large shared TM. Following a brief explanation of TM and demonstration of how the children would place their symbol cards on their talking mat, everyone took turns at placing symbols representing common foods (e.g. chips, burgers, tomatoes) on a three point visual scale under the 'Like', 'Dislike' or 'Unsure' categories to represent their preferences. As an example C3's first completed TM can be seen in Figure 4.9 below.

Figure 4.9 Child three's first completed TM

The children and I placed our symbols in either the 'Like', (right hand side of TM) 'Dislike' (left hand side) or 'Unsure' positions (centre) in regard to the topic 'school' (placed at bottom). This was largely a silent activity, apart from my occasional comment, which tended to be neutral and to maintain the task's momentum (e.g. *mmmm...I think I'll place this one here*). I did not comment as they made their selections which can be seen in Table 4.3

Table 4.3 Target group children's TM selections in relation to their likes and dislikes at school.

	Topic: School		
Child	**Dislikes**	**Not sure**	**Likes**
Child 1	Maths, Doing PE Group work in school	Tests, reading aloud	Raising hand in classroom, Singing, Spelling, School tour, Art, Drama
Child 2	Tests, Maths	Singing, Reading aloud	School Tour, Raising hand in classroom, Group work in school, Spelling, Art, Doing PE, Drama
Child 3	Test, Maths, Singing, Group work in school	Spelling	PE, Reading aloud, Drama, Art Raising hand in classroom.

No speech was needed to take part. When we had completed our selection, which took 2-3 minutes, I shared mine with the others and then asked each child to show their favourite school activity, their least favourite one and one that they were unsure about. C2 was the only child to speak during the activity.

Alderson (2008:45) points out that when we involve children in research, their views *'may yield surprising and, challenging and even contradictory findings'*. Surprisingly, the data indicate the children's liking for activities which require confident use of language (e.g. singing, drama, raising hand in classroom). This is contrary to expectations that tasks which require public use of language and some risk-taking might have been identified as dislikes. A second interesting finding from this TM activity is that all three children placed their Maths symbol under the 'Dislike' category. C1 and C3 both expressed a dislike for group work. These responses raised a number of questions for the researcher including whether

their dislike for group work should have been identified earlier, whether their dislike for group work was an indicator of their anxiety about performance with their classroom peers and whether their behaviour within classroom group work should have been observed before the intervention.

The Effectiveness Framework of Functional Communication (EFFC), used to rate participants' engagement with the TM method, was completed by the observer, who perceived the children to have engaged often during the TM activity. She also commented that the symmetry of the activity, described in the TM materials as the '*sense of equilibrium and balance that creates shared control in the interaction* was lacking (Talking Mats, 2012). The presentation of the activity for the first time located all the power and control with me. Had this become a regular activity in the intervention, the children could have managed their own materials and developed a greater sense of ownership in relation to the TM task. This would have created greater alignment with stated study's PAR principles (McTaggart, 1998). The LST gave a rating of 19 out of 28 on the EFFC framework. A score of 21 (i.e. 75 per cent of 28) is regarded as effective communication. On reflection, the TM activity demanded a considerable amount of organisation for little gain in engagement and therefore was not used again in subsequent sessions. The completed EFFC can be seen in Appendix 23.

Research question 2.2: What did the target group children perceive to be helpful or unhelpful when the intervention response mode was predominantly verbal?

The intervention mode was predominantly verbal during Sessions 1, 2 and 3 in situations when I spoke to organise the group, introduce a programme activity, when the children verbally guessed using one or two word utterances describing what another child had drawn on her 'MHC' card or when relaxation scripts were read. Data show that *children's participation* ranged between no response from C1 and C3, particularly to verbal prompts, during these sessions, to one and two word responses to prompts like '*I'd like to see what you have drawn on your happy card this week?'* (EP). The LST noted that C2 was the only child *'voluntarily talking'* in Session 1. The low level of verbal response from the children frequently left the session feeling very lifeless and silent for periods of 10-15 seconds during the first three sessions.

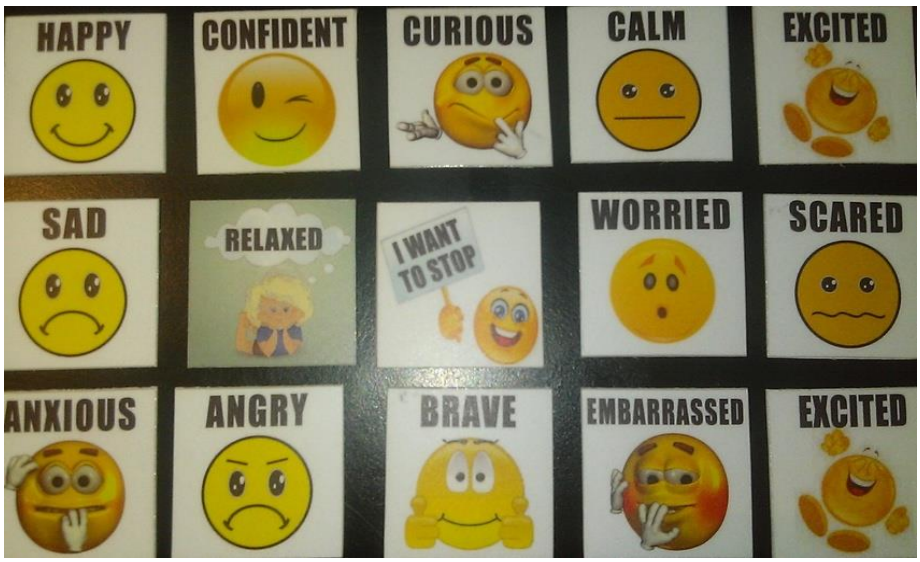
Guess the feeling or use emoticon cards

To build the children's ability to recognise feelings, I selected an image of a feeling (e.g. relaxed image c.f. Figure 4.10 Emoticons). I concealed it from the children. I role-played the felling or read from a pre-written text, which contained clues to that feeling, while the girls either verbally guessed the feeling or held up a card showing the feeling they thought matched the feeling I was reading about. One such script read as follows

> *Mary has just been to the swimming pool. She swam for ten minutes. On the way home she met her friend and had a nice chat with her. When she came home she decided to lie on her bed. She was not tired. She likes the feeling exercise gives to her. Her body feels loose and* she feels very ------? (i.e. wet (humorous guess), relaxed etc).

We took turns doing this activity. The children's positive non-verbal signals, when I humorously guessed a feeling they were trying to demonstrate, were perceived as evidence of an *enjoyable* activity for them. Guessing elicited useful, initial, low-demand, verbal engagement. They also smiled, giggled and nodded frequently during the guessing game. Importantly, the children did not need to provide an elaborate explanation in order to participate. They could choose to respond verbally or non-verbally. They were cognitively engaged with core *programme concepts* (i.e. Session 2 recognition of feelings). The Feelings Emoticon Cards which were used can be seen in Figure 4.10.

Figure 4.10 Emoticons



The guessing task was then configured differently within the group. C1 and C3 were paired with each other while I was paired with C2 to guess the feeling. They took turns to read the

script while role playing the specific feeling. The group dynamic changed significantly and a wider variety of responses was noticed. C1 grimaced for periods while her play partner role-played a feeling. She took a relatively long time to select a matching card when C1 and C3 were paired together. The children tended to make multiple, non-verbal guesses, using their small cards. C3 frequently shrugged her shoulders, possibly to indicate that she could not identify a feeling, when it was her turn to guess.

The demands of this activity, I perceived, gave rise to some *care and safety* concerns as the non-verbal signals from participants C1 and C3 suggested increasing anxiety during this activity. The anxiety may have arisen because the task demand was too high, because their role-play gave insufficient information to the partner, or because the scripts were not clear enough. I noted in my research diary a need to be sensitive in judging the pace of *programme delivery* to anxious children who may struggle to recognise feelings.

While these feelings recognition tasks may have been challenging for the children, it was decided to continue them in Session 3, when there was noticeably more *investigation and experimentation* of feelings than in Session 1. The children engaged in more verbal guessing of the feelings with each other and began to use words like '*kind of', 'you got it',* and *'that's it'* with their paired partners. Based this use of language and their positive body language, the children's participation was perceived to have increased during this activity. Additionally, there was a noticeable increase in accuracy of feelings recognition after three practices in this skill.

This concludes the findings in relation to research question two in which data supporting the use of the MHC cards as a novel method to effect non-verbal participation were presented. In contrast, Talking Mats as an activity was suspended. Guessing was perceived to be a useful intervention technique. Recognising feelings was judged to be difficult for the children. Findings in relation to research question three are now presented.

Research question 3: Helpful and unhelpful factors for intervention delivery (Aim 3)

What follows is a presentation of findings in relation helpful and unhelpful factors for intervention delivery with the children (3.1), the parents (3.2), the teachers (3.3) and at a whole school level (3.4). Ethical issues relevant to this intervention will then be discussed (3.5).

Research question 3.1 What factors helped or hindered intervention delivery to with anxious target group children?

Data relating to each child's application during the intervention show that C1 and C3 increased their *verbal output* most throughout the intervention. The LST observed C3's first instance of voluntary verbal output which occurred in Session 4 when she blurted out *'I got new shoes'.* This increased *verbal output* was helpful as it made programme delivery easier Additionally, grouping into pairs helped to take the focus off me. Opportunity was taken during sessions to pair C3, (i.e. child using very little verbal communication), with C2, a more talkative child, while I interacted with C1 the least talkative of all three. This created opportunity for me to engage in the low-demand guessing activities with C1 (e.g. guessing 'MHC' cards). When the intervention reached the end of Phase 4 (i.e. Session 12) I noted in my research diary

> *This work feels totally different now. The children come in eager to begin and wondering what will we be doing this week. The power balance has shifted. They want to talk about the school tour and stuff in relation to their home life. There is clearly more communication also between C1 and C3 particularly. The programme is coming to an end now though. I wish I had had this level of engagement at the start. I could have delivered the programme much better, gained more depth early on. The dynamic however was indeterminable and I had to work with what emerged*.

The PRECISE principles

The PRECISE principles (c.f. Figure 2.2) were an integral and helpful part of my approach to building therapeutic relationship and were constantly considered at Stage 3 of the PAR/CTG model when data were being analysed (c.f. Appendix 18). Data evidencing

helpful and unhelpful findings on each of the PRECISE principles used in intervention delivery (4.1) are now presented.

***Partnership* (P)**

In my actions within the intervention I was conscious of the need to engineer *Partnership (P),* into each session. In Session 1, for example, the '*Ideas to make the FRIENDS Club work well'* were carried out together. The children selected ideas presented to them or wrote their own ideas. The inclusion of the '*I want to Stop'* card, acknowledged the children's right to withdraw at any point, and helped to position me with less power than they might have expected. Partnering with each of the individual children for activities during the intervention sessions gave each child an opportunity to share a common goal with me such as guessing a feeling game or colouring together.

The small group setting provided opportunity to occasionally share personal, real-life examples of challenge with the group and to share my coping strategies. The judicious use of this strategy is considered useful within NEPS, when the rationale is clearly aimed at meeting the teaching programme objectives. In Phase 4, only, I played my guitar for the group. Thus, alignment with the children's culture through popular song was increased (C3 had recently started learning the guitar). In Session 4 the observer noted that '*the group is more together now'* and in Session 5 that '*they are more connected'*. Comments from C1's parents, coded under *partnership,* indicated that her daughter *'is more comfortable with you now'* after Phase 3. Parent 2 stated that this is useful *'psychological support'*. These comments evidence partnership.

As a self-reflection exercise I carried out a strengths, weaknesses, opportunities and threats analysis after Session 2 (i.e. a SWOT analysis) in my research diary and noted under opportunities that I needed to

> *Play more and simplify, offer choice and designate roles. No one said this would be easy, so get on with it!*

This suggests that I was struggling to establish *Partnership* in Phase 2, which may be a natural and expected characteristic of group work with anxious children. Stallard (2005) points out that children are used to adopting a passive role with adult authority figures. Further, a key tool to negotiate *partnership* which is dialogue between parties, was largely unavailable due to C1 and C3's reticence to speak.

Partnership inadvertently emerged more clearly in Session 4, and was more a product of the children's initiative in the context of joint attention to a shared story, rather than in the context of joint interpersonal alliance. *Partnership,* it is argued, can facilitate collaborative empiricism, where the child feels comfortable enough to test cognitions through experimentation, and to '*collect evidence that either supports or disproves'* these cognitions (Stallard, 2005:92). This was the case as is evidenced in the children's outputs from the Millie Stories.

Right developmental level **(R)**

Stallard (2005) guides that clinicians should ensure that the intervention is compatible with the social, cognitive and linguistic skills of the participants. As mentioned earlier, the *FRIENDS* programme content element that required most time in Phase 2 was developing the children's ability to recognise feelings. C1 and C3 struggled to make and recognise facial expressions of feelings. Their struggle with feelings recognition and expression may suggest that the *right developmental level* in this skill was lower than expected and that an easier entry level for this activity was required.

Interestingly, it was also noticed that C2 struggled to read some of the words written on cards, (e.g. '*curious', 'anxious'*). The class teacher indicated that anxiety is not a word found in primary school text books very often and this may have been a factor. This emphasises the need to ensure care in selecting both the spoken and written language of the intervention. The LST's recording of the positive responses to story-reading (i.e. heightened engagement), and of the exploration of feelings (e.g. C3's difficulty role playing a brave expression) was valuable information in relation to the suitability of material.

There was some evidence of the need for longer wait-time for C1. Her slowness to respond was noticeable both non-verbally (e.g. choosing TM cards in Phase 1) and verbally, even when the settling in period for the intervention had passed (i.e. Phase 2). Additionally, it was noticed that she frequently averted her gaze while planning her verbal and non-verbal responses, and that she appeared to have difficulty smoothly controlling her body movements during relaxation exercises.

***Empathy* (E)**

Stallard (2005:96) suggests that *empathy* (E) involves *'really understanding what the child is thinking'* and that '*the clinician's interest and curiosity promotes empathy and encourages the child to vocalise their thoughts, assumptions and beliefs about the world'*. The task is to try to view the world from the child's eyes and to adopt a warm, respectful approach, without patronising the child.

By starting with the 'MHC' cards, there was an immediate opportunity for me to show *empathy*. I simply looked at, and positively commented on, the drawing by each child on the card. I used my comments to validate the child's experience (e.g. 'I notice you were happy to see Granny'). I used a gentle voice to invite a response, and listened to the children's short utterances while trying to summarise what was in the picture. A key challenge here within the programme delivery, was the task of maintaining warmth and genuine interest without becoming overly patronising. In the process, I got to know a lot about the children's home lives, which was a helpful bonus in building up a profile of each child. Overall, limited data were available from which to draw conclusions in relation to empathy.

It was not possible or ethical to digitally record the dialogue from the sessions, so whether I managed to convey warmth and understanding is difficult to establish. However, comment in my research diary show my awareness to adjust my approach based on my sensing of the children's needs in relation to the length of the session (i.e. *'this lesson was too long'* Session *2),* and seating arrangements for tasks (i.e.*' an alternative seating arrangement might optimise their comfort'* Session 9*).*

***Creativity* (C)**

Creativity in this study is understood as the ability to flexibly adapt and tailor the delivery methods and media to the child's skills and interests. The use of the TM images, the 'MHC' cards, playing of the guitar, the introduction of a new character 'Millie', and the *FRIENDS* TV activity for UGTG group in Session 13 represented creative elements. Of these the Millie Stories were most frequently used to deliver newer programme elements like investigating readiness to change through the Stages of Change framework. An analysis of the children's output shows their consistent use of thought and speech bubbles, their colouring and decoration of their own Millie characters and their willingness to design special covers for

their Millie story-books. An example of the art work on C1's final Millie story can be seen in Figure 4.11

Figure 4.11 Child one's art work for her final Millie Story

The observer commented that this was *enjoyable* for the children and that they used their imaginations and '*brought the character to life'*. C1's mother commented that '*she enjoyed it...cos I saw her making the books and all the stories and the book covers and preparing herself this way'.*

C1 titled her final Millie story '*Millie's great worry fighting adventures'*. Inside her story book, as can be seen in Figure 4.12 , at a point where she attempted to convey how to keep her worry levels down at level 1 or 2, she wrote *'Breathe in, breathe out. Sky is blue, Grass is green'*. This evidences the integration of a new element in the *FFL programme* in relation to scaling worries.

Figure 4.12 Child one's example of scaling her worries

Breathe in, breathe out. Sky is blue, grass is green.

This is me on my last school tour

Interestingly, few concrete examples of how *children's interests* are integrated into intervention were contained in the literature reviewed. Stallard (2005:98) points out that the clinician needs to be comfortable with the idea of *creativity* and that there is an element of trial and error in working out what works within the intervention. A matching process is pursued which can have many signs of 'therapeutic failure' along the way. Whether this matching process should have begun in advance of intervention needs to be considered.

***Investigation and experimentation* (I)**

The *FFL programme's* theoretical model of early intervention for anxiety contains a number of cognitive elements with associated skills for application. These include practising self-

investigation of unhelpful thoughts (e.g. *'I'm going to fail the Maths test'*), paying attention through the five senses in order to reach a calmer state and using helpful self-talk and self-reward. It is proposed that '*the child should be an active investigator who tries out and evaluates ideas and new skills'* (Stallard, 2005:99).However, both of these approaches rely on a child's commitment and openness to risk-taking.

Data, coded as *investigation and experimentation (I)* in this study, indicate a number of findings in this regard. Firstly, when the children returned to the TG in Phase 4, having joined the UG for three sessions, their written output showed a higher number of incidents of investigation. C1 wrote '*Is there anything I would like to be braver at?* and *'Am I ready to be braver?'* She added *'Talk confidently to other people'* and '*practice*' as her strategy which she wrote about four times in her Small Steps Plan *(SSP).* Secondly, the data indicate that she was indeed making attempts to challenge herself to talk to others and that others were showing some receptivity to her. Her mother commented post-intervention

> *I could see changes in other children as well ... this is what I was saying. I don't know why, maybe it's because she was changing. But I had the feeling that the other kids were changing as well and that they were more accepting towards her.*

C3's increased *investigation and experimentation,* and willingness to take some risk, was also reflected in CT's post-intervention comments about her classroom behaviour

> *I notice it in the classroom a lot more... her hand is up, she's more outspoken she's not afraid to ask me a lot more questions, when it comes to Maths. She's not afraid to admit that she doesn't understand something.*

***Self-discovery and self-efficacy* (S)**

'There is a danger that when one is concerned with identifying dysfunctional cognitive process, that the model can become deficit driven' (Stallard, 2005:99).Data from the early sessions indicate that the MHC cards helped to counter the emergence of a child-deficit focus. The pictures the children drew on the MHC cards, for example, usually related to pleasant social events like granny's visit or getting a new book. Further, within the children's self-made Millie Stories is evidence that the children liked, and were perhaps copying, the approach used in Mike's Story, '*When My Worries Get Too Big'* in which Mike says *'I am awesome!'* having scaled his worries from a 5 to a 1. C1 wrote at the end of her story '*I am the best',* C2 wrote '*I can do it'* and C3 wrote that '*SSP's are awesome*'. These comments may have served to highlight their positive efforts to themselves and to counter the emergence of any negative feelings.

***Enjoyable* (E)**

To make FFL sessions e*njoyable,* predictability, humour, structure and pacing were evidenced as important. In this regard, I began writing the session's agenda on the white board, following C1's comment that we forgot to colour in our *FRIENDS* letter during Session 3. This was done to dispel any worry about what each session might involve and to create predictability for the children. Humour was also integrated in the EP's guessing about what was drawn on the MHCs (e.g. '*Is that your Granny in the picture driving the bus*?').

After Session 2, I was concerned about the risk of a dull and lifeless atmosphere developing within the group. This may have been a natural consequence of anxiety and novelty in that participants, including myself, may not have been relaxed enough to fully *enjoy* the sessions. The SWOT analysis, which is recorded in my research diary, gives some insight into the continuous challenge to make the work enjoyable

> *Strengths: The relaxation is improving: There is evidence of a very mixed group rather than a neat spectrum of participation.*
> *Weaknesses: Sessions 1 and 2 were too long; therapeutic relationship was poor; I'm not playing enough; there is poor verbal interaction; I'm unsure about their ability to recognise feelings; I'm feeling de-motivated already.*
> *Opportunities: I need to play more and simplify; offer more choice; designate roles; use blank cards more; probe school anxiety more.*
> *Threats: They may decide they do not want to come to the Club anymore; however, no one said it would be easy...so get on with it!*

Normalisation

It was important to consider the risk of stigmatisation for the TG due to their separation for periods from their mainstream class grouping for the intervention. In working to reduce this risk my role was *normalised* within the general school environment through frequent short visits to the classroom prior to intervention. This increased my familiarity with the children, and likely reduced the risk of stigmatisation.

Following discussion with the principal, a significant change was made after Session 5 to merge the TG and UG intervention groups in their mainstream classroom for Sessions 6, 7, and 8 as per intervention schedule seen in Table 3.2. There were a number of reasons for this: C3 had expressed some discontent to her mother at having to come to the '*FRIENDS* Club' following Session 3 viewing that '*the big group were having more fun.'* Additionally,

and with the exception of the 'MHC' cards, the 'Millie Stories' and the relaxation exercises, the participants showed little motivation to engage in *investigation and experimentation (I)* and explore some key *programme concepts* (e.g. Thought Challenger Game, Goal Setting, Role plays). A limited number of children's real world examples of challenges were available within the TG for these skill practices, whereas a greater variety and number of examples quickly emerged within discussions in the merged group (i.e. UGTG).This five-phase, two settings, approach that was eventually followed was unexpected, but in effect, led to the UG group becoming a resource for the TG.

Merging the two groups in Phase 3 helped to normalise the programme for the target group. The principal commented that she could see that TG participants seemed *'re-assured'* when they discovered that the programme was '*the same for the big group'*. Secondly, a greater variety of ideas emerged in discussions with the children. This was helpful especially for the Coping Step Plan element of the *FRIENDS* programme where there is a '*gradual exposure to anxiety-provoking situations*' (Barrett 2012:80). Overall, the benefit of merging the groups was a fortuitous discovery which was perceived as a normal part of the approach as was commented on by C3's mother who stated '*I think she just thinks this just happened naturally...I don't know if she has connected it at all, I don't think she has'*.

Cognitive Overload

Being a participant in the intervention was challenging due to the multiplicity of tasks. Finding ways to engage with the children and their silence, delivering programme content, gathering data while simultaneously ensuring *care and safety* gave rise to high level of demand on my attention at the beginning of Phase 2. This is likely to have impacted on *therapeutic relationship* initially when it was needed most. Part of this cognitive overload was the constant challenge to monitor the power balance within the group, to share the locus of control in order to optimise the anxious children's participation and to maximise the fun element.

Research question 3.2: What factors helped or hindered intervention delivery with parents?

Parents' awareness of their child's wellbeing, gave helpful insight into how anxiety impacts their children's behaviour. P1 described her daughter's tendency to '*always look for problems'* to '*worry about homework'* and that '*she is anxious because she is always worried'*. Parents' *sensitivity to differences,* in relation to their children's fears and worries,

were also evident in their comments. '*She's afraid of physical activity'* (P1); *'She's very sensitive and her younger sister is tougher'* (P2): '*She's a worrier, particularly about school'* (P3). P3 sensed low confidence in her daughter and described her as saying that she is '*easily knocked*' is '*shy around adults'* and as frequently saying *'I can't do it'* when faced with a relatively easy challenge. This background information was very helpful in the context of being able to prompt ideas for discussion particularly when both groups were together in Phase 3 and as confirmation that the selection of these children for the TG was justified.

A positive development during the initial Educator and Caregiver seminar (c.f. Table 3.3) was that one of the TG children's parents unexpectedly approached me after the meeting, and asked if her daughter could be a member of the intervention group. This is evidence that some parents were comfortable with the establishment of an intervention group and a universal group even at this initial meeting stage.

Two parents provided evidence for the heritability of anxiety in their identification of a *family similarity* in relation to anxiety in their respective daughters. One stated that *'She is quiet like her Dad. Her Dad was very shy as a youngster'.* Another spoke openly about her own, and her partner's mental health difficulties, stating that *'he's a chronic worrier and has few friends'.* She also described her tendency to air these difficulties on front of her daughter, and her worries about the possible impact on her having a *parent as a negative model.* She emphasised her own need to make contact again with her therapist, and her regret that she is not *'emotionally more available'* to her daughter. Thus, parental comment supports the proposition that parental cognitions may contribute to the intergenerational transmission of anxiety (Wheatcroft and Creswell, 2007).

The impact of the economic recession in the RoI was also echoed in parents' comments. When describing the impact on her daughter of on-going financial strain on the family one parent stated that

> *She is like myself, she is seeing it all, feeling it all and she'd be like myself, she's very emotive and she feels things like I would feel them, very sensitive. I don't know how she is as happy as she is to be honest.*

Another parent spoke about her daughter's insecurity when her father was absent from home for days at a time. Her behaviour becomes *'very clingy and she would worry about the doors being locked'* and *'come into my bed at night'.* This made me aware of wider contextual

factors which impact wellbeing at school. One parent stated that her daughter liked the project, but that she, herself, has been *'too caught up in my own head. I don't think to ask. I've had a lot of issues at home so I've been distracted really to be honest with you'.* Another parent stated that it was hard to '*get the information out of her and I didn't want to pry too much in case she got more suspicious'.*

A parent, when queried about the relevance of this kind of school work as compared to academic work, stated

> *I think it's great because a lot of children are not prepared for this kind of stuff in living ...they definitely go to the big world in the secondary school. I'm freaking out already.*

Overall, parents expressed *support for the project*. P1 acknowledged the usefulness of doing a whole class programme simultaneously, but also the suitability of a small group for her daughter stating that her daughter '*can talk about her feelings'.* As stated earlier, P3 was concerned that her daughter said she was missing her mainstream class, but when the intervention finished she stated to me that

> *its good cos like that you're thinking outside the box and it's not the traditional way and I think the alternative can help...cos each child has different needs...and sometimes they're not met in school*

Concern about their daughters' progress at school, and in some instances, about their own *parental wellbeing* emerged as themes from parent interviews. One parent, for example, described the isolation she feels among other parents in the community, her own mood variations and her inability to support her daughter. Also, there was also noticeable variability in what the *parents valued.* One parent placed little value in playing with her daughter saying that it is '*boring'* while another parent unexpectedly provided some craft material she and her daughter had been using for the targeted group to use during the sessions.

Finally, one parent questioned my use of the term '*intervention*' at one stage during an interview saying to me

> *I never heard you call it an intervention before* (change of tone, deep breath). *An intervention now stirs all sorts of things... it's like you're intervening when something is behaving really wrong, or bad, or is spiralling out of control and they need help.*

Following more discussion, she stated '*Support, I would call it psychological support'.*

Research question 3.3: What factors helped or hindered intervention delivery with teachers?

The principal's *communications with participants* (i.e. parents) when she introduced me as someone who is '*in and out'* of the school regularly, and stated that, as the school's EP, I have '*an advisory role'* were helpful. She indicated later that she was attempting to *normalise* the service by saying that, as the school's EP, he is *'constantly over and back to the school regularly.'*

She was initially concerned that parents would perceive the programme as an indication that the school needed specialist attention from DES psychological services '*because the parents think that the psychologist only comes to the school if a child has a problem.'* Further, during the meeting, the principal publicly asked questions about the programme, about where I had run it previously and whether it created an overly negative focus on anxiety. She stated later that she deliberately put herself '*in the position of a parent at the meeting learning about the FFL programme.'* She stated that in her experience '*when the parents see that the teachers ask the same questions, and we are parents ourselves, and on the staff here... it relaxes them a little bit as well'.* This dynamic gave rise to a number of useful questions from parents during the introductory meetings. This may have served to re-assure the parents about the *FFL programme.*

The role of the *teacher as an advocate* ,for *FRIENDS* in a small rural community, was helpful in *establishing a rationale* for the project. Firstly, as a teacher and school principal, she initiated contact with me following her observations of C1's withdrawn and anxious behaviour. Having read the *FFL programme*, she indicated its suitability to her school's Board of Management. Also, her grasp of anxiety as a concept seemed well grounded in current understanding

> *it's a very clinical word I think* (i.e. anxiety). *Because I don't think parents know that we all have anxiety levels anyway...that you have to have it anyway... that it's normal... it's fight or flight and that is it.*

Data from pre- and post-interviews show the principal's skills in *identifying anxiety* especially within teaching and learning contexts. When *teaching anxious children* she is aware of children who look around to check what others are doing, tense up at certain times, ask to do fewer questions, are eager to please, slow to transition between tasks and show fear

of raising their hands to speak. There was also evidence that her dual role of teacher/principal was an unhelpful, time factor, which reduced her opportunities to *identify anxiety*

> *I don't think we have a lot of opportunities to assess - to be around children, because teachers are taken up with so much schoolwork, corrections and relaying information to the Department. That's where the time is taken up. It's a time issue.*

She also stated that there are greater opportunities to notice anxious children outside of the classroom and when on school outings. However, she added, that *'these are rare occasions'.* Data also show the principal's helpful *classroom management* practices in relation to children's worries. She operates a '*worry box'* into which children communicate by anonymous written notes with her. *'It's anonymous and they like to know that I know their problems*'.

In relation to *programme concepts* the principal commented that some children had difficulty in identifying specific goals to use in coping step plans. The boys tended to relate their goals to sport and they were frequently very general. She queried, as did the LST, whether some of the vocabulary used to describe the programme concepts was too challenging for those with weak language skills. She pointed to an example in the teacher's *FRIENDS* manual in relation to the *programme concept* of support teams (i.e. Session 7 UGTG), where it states

> *Our Support Team is there for us in good times, offering unconditional care and love. These important people also relate to the attachment necessary to sustain us when trying to overcome difficult situations (Barrett, 2005:90).*

The teacher was frank in her comments about her own anxiety about introducing an intervention for children with social and emotional behavioural difficulties. She commented

> *I was a little bit anxious about setting it up because nobody wants to think that their child is stressed, or suffering from emotional problems or anxiety. It's Ok to be bad at Maths or English but when you're dealing with something that's kinda the unknown you can't put a bandage on that'*

Research question 3.4: What factors helped or hindered intervention delivery at a whole-school level?

In describing the *FFL programme* as being a '*match with existing programmes'* within the Social and Personal Health Education (SPHE) elements of the curriculum, the principal evidenced *school's openness* to engage with external services, particularly on issues impacting specific children. The principal was clearly concerned about one particular child

in her class (C1), who was *'suffering from anxiety for years and years...and because she was doing so well academically, it seemed to have gone by the way side'.* She commented that the *FFL programme*

> *kind of slotted in nicely ...because it's all about being positive and everything is green lights and green thoughts and everything is about embracing life and all its challenges and problems and trying to get over that hurdle.*

'FRIENDS may be implemented as a small group programme for selected anxious children' (Barrett, 2012:14). The principal drew on her experience of *teaching anxious children.* She did not want to pin point individual anxious children and therefore she supported a targeted group approach. This was helpful in *establishing a rationale* for the group and evidenced the *teacher's valuing* of targeted intervention for social and emotional aspects of children's development.

The pre-existing, whole-school practice, of selecting class representatives for various initiatives within the school like 'The Green schools' team, was used to gain the *children's participation* in the TG. The principal invited the three intervention group children to be class representatives for the project stating that '*If you feel like you're a captain you will take pride in it'.* This approach she indicated helps to reduce any sense of isolation or stigma and optimises their commitment to the activity. She stated

> *It was a way of getting these children into a group. These reps were the most anxious children and they may not have realised it themselves. So it was a way of getting these children into a group, in a roundabout way really. I really wanted them to take part ...if they are a rep they are more likely to stick at it.*

For *programme delivery* the principal favoured a *universal simultaneous to a targeted* approach as this might serve to *'dilute the stigma'* of being withdrawn from classroom. She indicated that

> *once their own class grouping also has a taste of what's going on, you know ... the children don't tend to question each other. Once the child gets a little bit of information about something, they are satisfied with that, and just carry on.*

Data also show the *teacher's valuing* of children's overall *wellbeing.* The principal evidenced this in her practice of guiding parents to maintain healthy perspectives in relation to academic attainment and school success generally. *Teacher judged* that there is a negative impact on *child wellbeing* since the reporting of literacy and numeracy test scores to parents

has become mandatory. She stated that *'that this is all the parents talk about now'* (i.e. the child's results from standardised tests).

> *if you didn't do great in your Irish this year you're going to have to do better next year and stay in and study' and do an extra half an hour of reading every night or you're going to have to write a story on Saturday to get good at this that's what some parents do and I don't agree with it.*

In particular, the principal had made efforts to guide parents about how to interpret annual, mandatory, attainment test scores, which may cause anxiety particularly in those students who are perceived as struggling. She finds that parents and children compare these scores and this puts pressure on children. She stated that when parents got her school guidance letter in relation to this, '*their focus shifted to not putting pressure on kids'.*

Data from the principal and two parents yielded interesting and similar findings in relation to the *screening process* for the project. The principal indicated that she did not like the title of '*The Spence Children's Anxiety Scale'* stating that

> *I wouldn't like someone handing something to me in fifth class saying the teacher is trying to find out if I'm anxious. It was too diagnostic and scary for them. I wanted it to be more like a survey, a survey on yourself, because we had done surveys before for the anti-bullying programme.*

The principal has responsibility for day to day *school management.* She finds in her contact with staff, that *'people don't talk about anxiety in the staff room'*. She finds, that in discussions about children who may be anxious, the terms '*self-confidence'* or '*self-esteem'* are more frequently used, and that in general, these discussions about social and emotional wellbeing are secondary to discussions about attainment. Data from the discussion with her also indicate a reluctance to use the term *'anxiety'* when writing school reports. Parents, she stated, first look for an overall comment on the school report about how a child is getting on and

> *you don't want to put down 'anxious' 'sometimes anxious' or 'can get nervous'. But it is often what you would talk about at a parent-teacher meeting. And if you did sense something you would have ear-marked the parent long before June....but I wouldn't ever write it on a school report.*

Research question 3.5: What ethical issues arise in relation to intervention delivery at school to children with anxiety?

Anxious children could be described as vulnerable (Banerjee *et al.,* 2001; Goodwin *et al.,* 2004). Researchers need to be aware of their '*possible heightened emotions'* and to collaborate with others to suitably individualise intervention programmes (Cleave, 2009:245).The process of selecting children for the intervention was informed by data from screening measures, and discussions with teachers. The children were then invited to be class representatives for the TG without the results of the screening processes being made known to them. It was unclear to me, how the school would have responded had one of the children asked: '*Am I being nominated as a class representative because I am anxious?*' Even though none of the children complained about being invited by the principal to be class representative, one could ask whether their unquestioning agreement to be class representatives was perceived by their teacher as their giving of consent.

In order to ensure the participants' *care and safety,* procedures outlined in Appendix 13 (i.e. *Care and safety review protocols for the 'FRIENDS Club'*) were followed. As it happened no child used the '*I want to STOP'* card during any of the intervention sessions. Only two instances of increased concern arose. The first, mentioned earlier, refers to C3's unhappiness at being in the TG group during Phase 2. The second occurred when signs of worry emerged in the behaviour of C1, following her experience of a story being read during intervention in Phase 2. The LST also observed her worrisome behaviour at this time.

While Lambert and Glacken's (2011) '*Elements of ASSENT'* were adhered to, there was a frequent need to consider the risks and benefits associated with all intervention activities (c.f. Appendix 17`*Elements of Assent*). This was difficult to do as in Sessions 1 and 2, particularly, as there was little verbal feedback from C1 or C3. Had the '*Elements of Assent'* been incorporated into the TM cards, this would have given the children a non-verbal mechanism to show their willingness or otherwise to continue, on a session by session basis. This may have facilitated a more respectful and sensitive approach to the TG children's needs.

I pointed out to the principal that the children could use the '*I want to STOP'* cards at any time during the interventions sessions. She responded by saying that if they were class representatives, *'this might discourage children from using the opt-out option',* adding later

that, *'I can't afford to have them opting out'*. She advocated for their involvement in the intervention because of their anxiety. Thus, the use of the class representative approach might have made the TG children feel that they could not use the '*I want to STOP'* card due to obligations to their class to fulfil their duties as class representatives.

Some professional practice issues arose in the context of my probing of the children's readiness to change. The question '*Is there anything at home or at school that you would like to be different?'* was asked. One could reasonably speculate about what might have happened had evidence emerged of a significant issue causing anxiety in a child's life, which warranted consideration under child protection practices. One parent had indicated to me that she frequently finds it difficult, for mental health reasons, to get out of bed in the morning and that this impacts her ability to support her daughter's regular school attendance. This raises issues in relation to child wellbeing, and whether I should have been more open with parents in advance about protocols in relation to disclosure. School was aware of this child's attendance record and was actively engaging with the parent to support her.

Conclusion

This concludes the presentation of findings. In relation to research question one the main findings were as follows: Surprisingly, only one of the three viewed the '*I want to Stop'* card, which was introduced as a care and safety measure to facilitate their disengagement from the group, as important. The children's perception of the relaxation exercises varied. Each selected different positions within the physical environment when doing the relaxation exercises and there was a consistency in their choice of calming imagery for relaxation. The evidence suggests that the TG children experienced role plays and identification of feelings as difficult. The children consistently showed a preference for writing and drawing, using a study-specific, child-selected character, 'Millie', when receiving core programme content like making Coping Step Plans.

In relation to question two, the MHC cards worked very well. They facilitated the children's participation and were, therefore, used in every subsequent session. My guessing, about what they had drawn, appeared to be enjoyable, and helped to build therapeutic relationship.

A second programme modification, Talking Mats, was used for two sessions in Phase 2. It was subsequently considered impractical and discontinued. The use of small cards showing

feelings (i.e. emoticons) was perceived as helpful in paired work within the group in relation to the development of emotional literacy (i.e. recognition of feelings).

With regard to research question three, the 'two settings approach' to intervention was perceived as useful in reducing stigma. The advocacy role of the school principal, and my pre-existing relationship with the school, as its school psychologist, were found helpful in establishing a rationale for the programme. The PRECISE principles proved useful in the maintenance of my relationship with the three children who presented as silent and reticent at the beginning but significantly more participative in later phases.

Chapter 5 now critiques the findings in more detail. It introduces a discussion about the study's three concepts, application, programming and cognitive-ecological context, which are proposed as relevant to targeted intervention for anxious children. Implications for the practice of educational psychology will also be discussed.

Chapter 5 Discussion of Findings

Introduction

This study explored perceptions of a targeted intervention based on *FRIENDS*, and delivered by an educational psychologist to three sub-clinically anxious children in a four-teacher, ordinary, mainstream mixed primary school in the RoI. In carrying out the intervention, I also took the opportunity to reflect on my practice in relation to working with this population of children, their parents and teachers. This chapter aims to

- critique the study findings in relation to the three main concepts which emerged from the data, namely, the application, programming and cognitive-ecological context of interventions for anxious children
- critique my practice as an educational psychologist with anxious children
- introduce a number of broader implications for educational psychology which will be developed further in Chapter 6.

To begin this discussion, it is important to consider whether the target group children, to whom the intervention was applied, had a positive, beneficial experience. The absence of negative comment about the intervention cannot be taken as evidence of a positive experience. In light of '*the status and power differentials'* extant between the children and me, they were arguably least well positioned to provide critical comment (Christensen and James, 2000:31). Findings suggest a positive change in the children's participation in the intervention once a suitable modality, namely, the use of narrative to carry the programme content, was identified. An improved therapeutic relationship with the children was also apparent in the examination of how the PRECISE principles worked.

The children's experimentation and investigation of core *FRIENDS* content was apparent as the children worked busily on their narratives. Bannister's (2003:20) suggestion that vulnerable children, when they engage with creative methods and materials, are working in '*the space between'* resonates here. This *'space between'* Bannister suggests is an intermediate space between the unconscious and reality which is necessary for their development. The children's participation in the more creative elements of the intervention appeared relaxed. Their emersion in story narratives, it is argued, allowed them to enter this imaginative space. Further, the useful group cohesion created by our participation, as a

group, in narrative during the intervention is potentially useful insight in light of argument that '*the quality of the child-therapist alliance assessed early in the treatment may be differentially associated with the symptom reduction at mid and post-treatment'* (Chiu *et al*., 2009:751). The use of story was crucial to the development of this therapeutic relationship.

Application of the *FRIENDS* programme

Little has been written specifically about the application of FFL content through story. Perhaps this is because the FFL session material already contains some stories about fictitious children (i.e. Tom, Annie, Lucy) (Barrett, 2010:10). However, a key difference in the findings of this study was that the use of story was very much an organic development, as it emerged naturally through the initial engagement of the children with a book which was brought voluntarily by one of the children to the group. No other specific study has been located about the use of story when delivering *FRIENDS*. The book's theme had no apparent connection with the FRIENDS programme material. As mentioned in Chapter 4, the children's subsequent increased engagement with story-writing was noticeable, and lead to the creation of this specific study's own fictitious character, Millie. Her use in subsequent sessions appeared to stir the imagination of the children to vicariously experience circumstances they may otherwise have considered scary or anxiety-provoking (e.g. '*I want to be able to stop being shy around adults I don't know very well' Figure 4.*5). This vicarious experience may have been possible through their ownership of the character, who was chosen and named by the group.

It is acknowledged that these methods are not new and have been traditionally associated with psychotherapy and psychology, and perhaps more recently with mental health and helping disciplines (e.g. Noble, 1994; Mazza, 1999). In commenting about the therapeutic use of fantasy characters to help children overcome challenges, it has been posited, that a child can '*live an experience with a character as an alter ego that eventually is assimilated into the child's original ego'* (Pehrsson and Pehrsson, 2007:42). Gladding and Gladding, (1991) argue that children who read materials designed to address problematic thoughts and behaviours are likely to experience change through catharsis, insight, or the copying of character behaviours. This study's approach, I propose, is suitable with small groups of children with elevated anxiety levels as the story context can be more comfortable for the

children to explore their characters without having to continuously interact directly with a facilitator.

Critically, if this use of children's fantasy through creative story-writing is viewed as useful, then one must examine what parallel facilitator approaches might be suitable for an EP to use in the context of transporting CBT-based programme content (i.e. FRIENDS) to children with mild to moderate levels of anxiety. The FRIENDS manual suggests that facilitators should help children to learn that they have the power to control their thoughts themselves and to feel good. It encourages experiential learning, peer learning and the use of supplementary material or new ideas for programme delivery which can come from the participants themselves. Broad guidance is provided in the manual on useful skills for leading group intervention. These include the use of positive reinforcement, giving specific feedback, paraphrasing and reflecting feelings back to the participants (Barrett, 2010:27). However, it should be pointed out that these are verbally mediated facilitator activities, which proved problematic in this study with the intervention children, possibly due to the risk of facilitator dominance. During the first three sessions during this study the children's verbal engagement was minimal. Their verbal and written outputs would have been insufficient to sustain programme delivery. Thus, the use of the children's fantasy interests became a significant resource within the intervention.

It can be argued that specific guidance on how to build group cohesion and tap the natural interests of children are under-emphasised elements in the FRIENDS approach. Other models provide more specific guidance on these elements. The Language Fantasy Approach (LFA) (Pehrsson and Pehrsson, 2007), for example, provides guidance about the therapist/facilitator actions which help children to create, control and encourage their character to examine their own challenges which '*naturally flow from their own lives'(*Pehrsson and Pehrsson, 2007:47). This three stage approach provides description on helping children to establish their individual story character, encouraging the character to make brave choices and on bridging from the group's constructed story world of the character to the child's life. Crucially, the emphases are placed on the child making brave choices and on being in charge of their imagined character within the group's created story and not their individual story. The story is created by the group and the individual fantasy characters are used by the individual within the group work context. This approach, it is argued, could have added to group cohesion in this study.

Additionally, it is argued that the children can learn the '*advantages of cooperation as they work together to solve problems'*, and examine their own challenges while remaining sufficiently distant in their fantasy character, to experiment (Pehrsson and Pehrsson, 2007:46). This could have created greater exposure to the intervention activities offering self-discovery, investigation and experimentation for participants elements contained within the PRECISE principles used in the study for building therapeutic relationship.

Finally, a CGT approach was used in this study's research model. This necessitated a researcher focus on emerging leads from the individual children as the key determinants of the direction and modality for programme implementation. Data from individuals were analysed when more data relating to group dynamics may have been useful also. Critically, this may have reduced opportunity to explore more group-based activities. A greater focus on data showing the factors which served to connect the children to their group may also have served in the cultivation of an '*enabling climate'* for the FRIENDS work (Horstman *et al.,* 2008:1010). The resultant effect was that the three children being supported, wrote about three individual Millie characters, when a group story, with three differently named, but individually developed characters, contributing to one group-owned story could have been more useful.

Critique of frameworks which guided application

The PRECISE principles (c.f. Figure 2.2), used to optimise the therapeutic relationship, and the Stages of Change (SOC) model (c.f. Figure 2.3) used to guide my judgement on readiness, were both considered in the context of my professional application as an EP during this intervention. These frameworks are now critiqued in terms of their usefulness for group work with anxious children. While it is not claimed that the group work was therapy in the traditional sense, it is the case that there were opportunities within the intervention for focused consideration of the children's readiness for change through the SOC model.

Readiness for change can be illustrated in a client's movement from being '*unmotivated to make any change to considering possible targets and then deciding and preparing to make some small change'* (Stallard, 2005:10). The author argues that the SOC can help the clinician to guide and pitch the focus of the therapeutic process at the most appropriate level. In other words, knowing where a child's motivation lies in relation to these stages is

considered helpful. Overall, this task of knowing proved too elusive for a number of reasons. Firstly, I had little verbal feedback to evidence the participants' respective positions in the SOC cycle particularly in Phase 2. Secondly, the model is based on the gradual development of awareness and ownership of a problem or discrepancy in the person's life. This problem focus is, however, de-emphasised in the *FRIENDS* programme which guides its facilitators to avoid an examination of any values and beliefs underpinning problems, and to make the programme implementation skill-focused and fun. Thirdly, reflection indicates that more data were needed in relation to the children's actions within the home and school environments to inform whether new skills were being used (i.e. Action stage).

Some data in this study indicate, nevertheless, that the children were able to identify potential areas for change on their own (e.g. Response to question: 'Is there anything at home or at school that we would like to be different?).This evidence began to emerge in Phase 1, Session 4, in the context of exploring unhelpful thoughts, and later in Phase 4 when the children began to set goals for their small step plans (SSP). Within the SOC model (c.f. Figure 2.3), this identification of goals takes place within the 'Preparation' stage. People in therapy optimally move from pre-contemplation to contemplation and onto preparation stages of SOC by using consciousness-raising and self-liberating techniques (Stallard, 2005). Thus, direct awareness-raising in relation to the children's individual anxious behaviour at school was avoided. If one considers relaxation to be self-liberating, then this did occur. In effect then, this model may need revision to accommodate other kinds of signalling beyond speaking.

There is also the question of timing, in that some of the children may show signs of readiness earlier than others, thereby impacting group cohesion. Stallard (2005:3) advises that

> *Confronting or challenging the child's resistance is avoided since attempts at direct persuasion, argument or challenging result in a polarisation of views, which only serves to strengthen the child's position*

Instead of focusing on identification of areas for personal change in the pre-contemplation and contemplation stages, and risking damage to the therapeutic relationship, a sensitive, less risky approach with children is advised where signs of their self-efficacy are reinforced. A focus in a more general way, on children's readiness for change, is advised (Stallard, 2005). This would seem to align more closely with the *FRIENDS* approach, which emphasises the identification and expression of inner thoughts, techniques for challenging

unhelpful self-talk, challenging biased interpretation and evaluating performance in terms of partial success. This balance between preserving a therapeutic relationship and guiding children who may be unaware of their own social and emotional strengths and needs, is a tension that existed in this work.

The PRECISE principles

EPs need in the first instance, to show behavioural flexibility, sensory acuity and an ability to reach congruity between non-verbal and verbal messages when working with children (Beaver, 2011). This is relevant in the context of the substantial literature relating to the importance of the clinician-client relationship (Crits-Christoph *et al*., 2013; Brouzos *et al*., 2014). The *FRIENDS* manual guides that programme sessions should be a time for *'fun and emotional awareness'* (Barrett, 2012:15). Data show that this was difficult to attain in Sessions 1 and 2, which were characterised by long silences and little voluntary, unprompted fun-based action from the children. It was difficult to gain understanding of how the children were experiencing the intervention during this period. Knowledge gained from my application of *FRIENDS* content in these sessions suggests that greater differentiated use of the PRECISE principles would have helped to avoid, what Stallard calls, the '*therapeutic pitfall'* of the clinician working too hard to bring everyone along the path towards more comfortable engagement without raising any resistance or disengagement.

The data also suggest that not all of the PRECISE principles carried equal value at these early stages. In particular, investigation and experimentation (I) and self-discovery and self-efficacy(S) are more individual tasks. They only come into focus after the partnership (P) has been built up through activity at the right developmental level (R) which is enjoyable (E). These three principles (i.e. PRE), it is proposed, may need more emphases early in the intervention. Thus, building an enjoyable partnership, which is grounded in a culturally valid approach with anxious children, precedes investigation and self-discovery. I hold that initial partnership working with children is not emphasised enough for facilitators in the *FRIENDS* programme. The programme content and objectives move very quickly to cognitive skill-development without reference to the children's readiness.

Beaver's suggestion that '*more specific, rapport-building'* skills need to be integrated into EP practice had resonance for me during the periods of significant challenge when the children spoke little during the initial sessions. While these skills formed part of my initial training in educational psychology, focused and specific opportunities to practice them with

specific populations during an EP career is scarce, because existing models of practice require much consultation with teachers as opposed to intervention with children. Continuous professional development opportunities for EPs need to include more *in vivo* skill practice with children, as opposed to theoretical explanations of approaches to intervention which EPs commonly give to teachers.

The principal's role

The role played by the principal teacher is also relevant in the context of a discussion about application of the *FRIENDS* programme. As mentioned earlier, there is considerable societal fear of mental illness, which is represented in the associated language and discernible *'pejorative distancing attitudes'* (Weare, 2000:99). The actions of the principal in normalising my involvement with the anxious children in school, in mediating the rationale for the programme, in reducing the possibility of any discrimination that might have occurred for participants and providing re-assurance about the care and safety elements may have helped to reduce the parents' and children's anxiety about taking part. Apart from the care and safety elements of this study, none of these roles that were adopted by the principal were pre-negotiated in advance. The principal automatically read the needs of the situation as the intervention was being introduced to parents and filled the gaps in understanding, thereby, showing her excellent leadership and support for the programme.

Thus, the principal acted as a useful bridge between the school community and me as a professional. These helpful contributions by the principal are likely to arise when EPs *'partner with families, teachers, school administrators, and other professionals to create safe, healthy, and supportive learning environments that strengthen connections between home, school, and the community'* (NASP, 2014). In the UK and RoI, however, EPs offer consultation and advice to parents and teachers, usually at school. A limiting factor in the development of partnership with parents for EPs in RoI, and within the NEPS model arises from the fact that EPs do not visit children's homes. This project highlights a potential benefit to community health in EPs carrying out home visits. EPs could sensitively build communication between home and school, focus on establishing links for parents to community health structures, and learn about children's established coping strategies which could be used in an intervention.

As mentioned earlier, the principal's leadership was perceived to have had a positive bearing on the intervention. The important role that school leadership plays in positive mental health

has been cited in many reports (e.g. Kam *et al*. 2003; West, 2006). One relevant leadership skill, that is proposed, is the skill in '*lateral capacity building'* (Fullan, 2008:11).This refers to building the capacity of students, teachers, parents and caregivers, as well as outside mental health service providers (e.g. EPs) to aid the school's approach to wellbeing. No literature, however, on the role of school leadership in building capacity with a school psychologist or on approaches to the early identification of anxiety by teachers for subsequent intervention in mental health has been located. This may in part be due to schools' perceptions of EPs as a '*fire-fighting service, one that is geared towards emergencies rather than prevention or early intervention'* due to inadequate funding in education (Rothi *et al.,* 2008:134). Finally, a possible barrier to building lateral capacity with EPs, mentioned earlier, may also be the frequent linking of the EP role in RoI to resource allocation (i.e. schools prioritising casework over early intervention work in metal health).

Daly's (2008) concept of '*principal-patronage'* is also relevant in relation to the concept of application in this study. Daly (2008) highlights the role of patronage with at least one '*practitioner catalyst'* in the school to distribute ideas to other teachers to embed practices. I view leadership and vision within the school as crucial to gaining buy-in from schools for intervention work. Perhaps there is more professional space than imagined for a school-based psychologist to act as a *'practitioner catalyst'* in providing examples of flexible inclusive practices referred to by Travers *et al.,* (2010:45).

This project involved me as the school's EP working in partnership with school staff. Successful practitioner/researcher partnerships in local communities of practice are complex social processes between colleagues from different settings with different experiences, beliefs and assumptions. The parties involved need to learn from their differences (Ainscow *et al.,* 2006). The principal indicated her concerns about one girl *'because she is so vulnerable ... she is the most vulnerable person l have ever seen'*. Yet she was prepared to explore new approaches within existing SEN provision to find a way to support her. When head teachers adopt an '*enquiring stance'* this can lead to a *'rethinking of assumptions and the development of new ways of addressing barriers to participation and learning* (Ainscow *et al.*,2006:127*).* When there is an interruption in thinking, a space for new practice emerges. Barriers to new practices occur through '*conflicting agendas'* and beliefs which may prevent experimentation. For educational psychology then, the task is to help schools to challenge their assumptions and to embrace change for specific purposes.

In summary, there is evidence of positive benefit which accrued from programme application with the children. Frameworks applied during the intervention are promising in terms of facilitating cognitive behaviour based interventions with targeted children. The use of story-writing as an application strategy, it is proposed, has potential for greater use with groups in the context of the FRIENDS programme delivery to anxious children. The leadership of the school principal is also an important factor in establishing a space within a community for this type of targeted programme. The next section discusses some of these new programme activities which served to deliver *FRIENDS* programme content to the children.

Programming for application of *FRIENDS*

Programming, as a concept in this study, refers to the introduction of specific intervention activities to carry *FRIENDS* programme content. While the recommended sequence of content delivery was followed in order to maintain fidelity to the programme, the modality of delivery in these activities was modified to optimise non-verbal participation of the children who presented as anxious and reticent. This approach to intervention aligns with Kendall and Beidas's (2007) call for flexibility within fidelity, where core components of intervention are customised in their delivery to meet the child's needs (Kendall *et al*., 2012). Being a participant in the actions of the intervention gave me a bird's eye view of the children's responses to the refinements made to the programme activities, from session to session, in line with action research approaches. The iterative process, through which refinements were made, is illustrated diagrammatically in Appendix 18 (i.e. *Data analysis process*). The following is a discussion of four main refinements to the programme activities as they were introduced.

My Happy Cards (MHCs)

The MHC cards were used to begin all sessions with a joint-focus on a drawing of a happy event in the child's life. While many worksheets are available in other manuals for similar purposes (e.g. *Think Good-Feel Good,* Stallard 2002a), these cards offered advantage. They were bright and colourful in design, could be easily shared, were re-usable and offered opportunity for my co-participation in a fun way when, for example, humorous guessing was engaged in. With children who are reticent or unforthcoming, the clinician may adopt *'a rhetorical approach in which they muse aloud a range of possibilities for the child to select'*

as opposed to using the traditional approach where the child simply sits in a chair and talks to the clinician (Stallard, 2005:120). Manassis (2009:90) cautions, however, that *'the child has little idea what to expect from you and what you will expect from him or her...and may not report distressing symptoms'*. Showing interest in the child's world, starting the work together, praising minimal participation and even using some limited self-disclosure, she argues, can help build trust. The MHC cards fulfilled all of these purposes and became a key tool in intervention delivery.

Drawing has been used as a way of effecting communication with both healthy and ill children, and also with children who may find it difficult to convey their feelings verbally (Hill, *et al.*, 1996). Methodologies which have used drawing have generally been found by children to be fun and enjoyable (Bradding & Horstman, 1999; Pridmore & Bendelow, 1995). Horstman *et al.,* (2008:1002) also contend that the act of drawing '*takes the focus away from the adult researchers asking direct questions, and instead provides a child-centered way that the lived experience can be shared'* . One of the inherent disadvantages, however, lies in the fact that it can be difficult to analyse the drawings. Some published studies, therefore, using the draw and write technique do not include an analysis of, or discuss the content of, the drawings (e.g., Smith & Callery, 2005). However, in this study, the drawing technique was used only for the purpose of creating an '*enabling climate'* (Horstman *et al.,* 2008:1010). Pictures were taken at face value and not analysed projectively, thereby, keeping adult interpretation of the activity to a minimum during this activity. This, I propose, was important in the maintenance of the fun element.

One could reasonably ask whether there was greater potential in the drawing technique used in this study. Could it have been used at a group level with these anxious children, in a similar way to the earlier proposition about the use of a group story? In this regard, some usefulness lies in Horstman *et al.'s,* (2008) description of the use of prompt questions with children who are ill, in a way that does not lead the child in to what to draw, but frames his on her thoughts to give information about a specific topic. Crucially, Horstman *et al.,* (2008) point out, that it is important to leave the child in peace during drawing to prevent contamination of their ideas, but to verify with the child the content of the drawing. Also, and in terms of potential benefit to this study's approach, having an explicit understanding with the children that drawing can be an enjoyable, quiet time for everyone at the start of each session might have been beneficial. It might have helped the children with their

transition from the busy classroom environment to the 'quieter' FRIENDS group work context where the activities were, arguably, not as pressurised as classroom activities for them.

Ideas to make the *FRIENDS* Club a success

The children selected, from a list of ten ideas, their top five ideas to make the FRIENDS club a success (c.f. Table 4.2 *List of ideas to make the FRIENDS Club a success*). Having ground rules is experienced as reassuring by most children (Manassis, 2009). I was conscious, however, not to use the term 'rule' when the ideas were being selected due to its associations with compliance. A more positive slant was given to the activity, and crucially, the children were given opportunity to write their own ideas. This was an attempt to co-construct understanding about how we could get along with each other to promote the emotional comfort of the participants and to ensure they had a mechanism to effect disengagement at any time if they needed to do so. During the intervention, no child selected the idea '*If a person becomes uncomfortable they can raise the 'I want to Stop' card and no one will make a fuss about this'* during the selection process. There may be a number of reasons for this. It may suggest that the children were confident enough to state verbally that they wanted to stop if they needed to and didn't need the make use of the card. Perhaps they didn't envisage a need to stop ever arising or perhaps they were uncomfortable with the idea of using such a card in case there would be an investigation and their actions would attract negative attention.

Feelings Cards

During early sessions, the findings revealed the children's slow identification of emotions as represented in facial expressions on 'Feelings cards' shared with them. This is unsurprising, given that anxious individuals make errors in interpretation of their experience (Beck, 1976), misjudge their ability to cope with neutral stimuli (Mathews and McLeod, 2002) and are more likely to interpret ambiguous situations as threatening (Butler and Matthews, 1983). There may be a number of other explanations based in their level of cognitive functioning for this slow uptake of learning. Research suggests that anxious children have '*unique socio-emotional difficulties'* and their impaired emotional perception may require specially tailored therapeutic attention (Manassis and Young, 2000:209).

Another view posited is that there may be *'systematic difficulties specifically in visual non-verbal communication that contribute to the personal and social difficulties socially anxious*

children experience (Walker, *et al.,* 2011:293). It has also been found that children with social anxiety fare poorly relative to their peers in identifying facial expressions, and that these erroneous perceptions lead to poor evaluation of social situations. Perhaps some strategic pre-assessment and post-assessment of emotional literacy could compliment the anxiety measures carried out (e.g. *Emotional Literacy Checklist,* Faupel, 2003). These could inform a debate to determine whether the *FRIENDS* programme can effect gains in the area of emotional literacy.

In contrast to the usefulness of the simple use of drawing in this study, described above, difficulties arose for these anxious children using one of the study's other non-verbal elements, (i.e. the use of emoticon cards and pre-written scenarios to identify emotions seen in Figure 4.10). This element was introduced to fulfil a learning outcome of Session 2 of FRIENDS '*that participants should show an understanding of feelings experienced by themselves and others' (*Barrett, 2010:31). This raises an issue in relation to the task complexity of this activity. If one accepts that children gradually develop their comprehension of emotions, can differentiate between two categories of emotion (e.g. happiness and sadness) at an early age, and that their understanding of more complex emotions (e.g. fear, anxiety, anger, disgust) develops later (Brechet *et al.,* 2009), then it is logical to conclude that participants in this study may have been at different points on this developmental path to emotional understanding.

Critically, this points to a need for some element of a gradual and staged introduction to feelings and recognition of emotions, from simple to complex, for the anxious children who may have had a narrow range of life experiences on which to develop their skills in this area (Lebowitz and Omer, 2013). To this end, Brechet *et al.,* (2009) propose that children's understanding of basic emotions can be assessed through their drawings. It is argued that drawing can elicit a more precise understanding of their emotional understanding, since it *'requires explicit analytic understanding of emotions and their human experience, compared with tasks involving photos, in which success can be achieved with a more holistic appreciation of the stimulus' (*Brechet *et al., 2009:604).* The increased use of drawing would, I propose, require some interpretation by the facilitator of children's expressive drawings within a projective approach (e.g. Thomas and Jolley, 1998). This would represent an activity which goes beyond the limits of a FRIENDS facilitator's brief for EP s and the programme's basic rationale.

The interconnectedness of working memory and anxiety on each other is also worth considering in the context of C1's slow response during sessions. Research shows that anxiety-related, worrisome thoughts, generate cognitive interference which requires the learner to rely on auxiliary strategies which impose additional demands on the central executive component of the working memory, thereby impacting learning (Baddeley, 1986). Cognitive confusion like the inability to recognise feelings in pictures increases state anxiety, which in turn reduces working memory capacity, which in turn leads to misunderstanding and uncertainty in information processing (Grimley *et al*., 2008). Thus, the interconnectedness of cognitive processes needs to be borne in mind when considering the loading on memory associated with any activity presented to the children.

Engagement with narrative

To make their work more distinctive, EPs should attempt to uncover *'mediating/psychological knowledge to create situations with specific outcomes'* (Cameron, 2006:289). The TG children's engagement with narrative, both through listening to stories and writing their own Millie Stories, makes this work distinctive. A simple stick figure representing a girl, named by the group as Millie, served to carry the *FRIENDS* programme content through Phase 4. A number of possible reasons for this increased engagement with narrative are proposed. Firstly, perhaps the children felt more comfortable when they were imagining. When I read a story, there was no need to worry about the demands of conversational turn-taking. Alternatively, when they wrote and used their speech and thought bubbles to convey ideas, perhaps the programme content was perceived to be easier and within their competence as learners. It was observed that the children were straining and standing up to gain a view of the story material being read. This suggests an engagement based on intense interest and some excitement, perhaps, to find out more about what would happen next in the story. This finding replicates that of Clarke (2011) in the evaluation of a similar type of primary school universal intervention, *Zippy's Friends,* in which classroom observers and teachers reported the positive influence of the stories on the quality of the lesson being delivered by the teachers. This finding supports argument for greater focus on using story as a method to engage children in teaching and learning of the *FRIENDS* programme content.

In this study children's participation was optimal when they were using an imagined character Millie. In proposing that '*imagination appears in some disjunction between the*

flow of embodied experience, anchored in the unfolding reality, and the flow of inner life or consciousness' I hold that imagination can help to create distance, one's own zone of proximal development, using one's own internal *'semiotic means, among which is language'* in order to '*radically allow new perspectives'* (Zittoun and Cerchia, 2013:321). In challenging the traditional view of imagination as not being as good as reasoning, it is argued, that imagination can have the same level of complexity as other thinking capacities and can create an '*as-if mode which can be fictional, playful, hypothetical, counterfactual, retrospective or prospective – to create a mental plane, alternative realities, recomposing the given or enriching it'* (Zittoun and Cerchia, 2013:321).

The work of Geldard *et al.,* (2009), points out that up to forty per cent of children do not respond to cognitive-based programmes requiring verbal discussion. Methods which employ creative and metaphorical processes like drawing, offer greater opportunity to '*develop and increase understanding and awareness of emotional competence in children who may not yet have developed the ability to cognitively report on their abilities'* (Geldard *et al.*,2009:10). Other EPs have found, in a similar way, that children naturally draw on their imaginary friends for '*comfort, distraction, support and/or problem solving when events in real life were upsetting'* (Majors, 2014:20).

While the use of creative approaches in teaching and learning has always been recommended, no comment in relation to its usefulness to carry *FRIENDS* programme content to anxious children has been discovered in available literature. I propose that the development of these imagination-based creative approaches can offer anxious and reticent children the opportunity to enter '*the space between'* and can increase therapeutic edge, and perhaps provide access to teaching tools which are constructivist in nature. The question as to whether CB approaches should be embedded more in stories and other narratives to help those less likely to use cognitive/language based approaches in learning is also relevant. Findings in this study supporting an increased use of metaphor and greater engagement with imagination, point to the need to front-load these approaches to carry CB programme elements to anxious children.

In summary, the use of narrative, has been emphasised as key to the successful implementation of the *FRIENDS* programme in this study. The approach, I propose, has potential to engage the children's imagination during programme delivery, thereby creating

greater emotional comfort and freedom for them to relate. It has been proposed that this method has wider utility. It can be used to stir the imagination and engagement of children and as a conduit through which proven cognitive behavioural intervention based skills can be introduced to them. The next section discusses findings relating to cognitive-ecological factors which are relevant to the implementation of targeted interventions with anxious children.

Applying the FRIENDS programme in distinctive cognitive-ecological contexts

Children learn in a variety of contexts. School, as a context where children in RoI spend approximately six hours daily, their cognitive, emotional and behavioural development and their subsequent academic skills. *'There is growing recognition of the important contribution schools can make to the psychological wellbeing and emotional health of children'* (Stallard, 2010:32). It has been referred to as one of

> *the nested contexts of child development, providing a stage for social interactions, opportunities for social engagement, and a normative or regulatory structure that includes costs and benefits of distinct courses of action* (Guerra, *et al.*,2005:277).

Guerra *et al.,* (2005) propose a cognitive-ecological view of children's learning, and hold that problem behaviours arise from interactions between individuals' predispositions and contextual socialisation. Within the cognitive-ecological model, individual, situational and environmental factors are emphasised for important understandings in relation to the fundamental problem which can help to derive an intervention approach. The individual factors include temperament and personal characteristics. The situational factors include perceptions and stress. Environmental factors include family, neighbourhood and social characteristics.

In order to advance our understanding of how to prevent and intervene when necessary, practitioners should *'expand notions of cognitive development to incorporate multiple contexts and interactions'* (Mayer *et al.,* 2009). Recent developments, for example, identify the health and wellbeing of people as being influenced by connectedness and relationships between the intrapersonal, interpersonal, organisational and communal system which operates within a locality (e.g. Green and Kreuter, 1990; Stokols, 1992, Dooris, 2009). In

this study, an expanded model is proposed which includes, not only specific cognitive-ecological factors relating to the nested context of school and children's learning, but also factors relating to the personnel who engage with formal schooling like parents, teachers, children, psychologists, and other visiting personnel. Study findings in relation to cognitive-ecological factors relevant to future development of school-based, targeted interventions by EPs in the future are now discussed. These factors are considered important for school psychologists given that '*about 20% of children with mental health problems typically come to clinics but 100 per cent of children are obliged to go to school!'* (Manassis, 2009:148).These factors will be discussed in relation to the child, parent and school.

Child

The three children selected for this intervention were individually very different in terms of their anxiety levels. This variability was very noticeable within group work through their differential levels of reticence and speaking behaviour. This is relevant given that some have encouraged clinicians to view conditions of childhood, like anxiety, as dimensional, and for clinicians and researchers in gauging the severity of a disorder, to consider subclinical presentations and changes over time by repeated assessment rather than an all or nothing approach (e.g. Le Beau *et al.,* 2012). This dimensional approach can capture more substantive heterogeneity associated with the existence of other co-morbid conditions.

One parent's unsolicited request for the inclusion of her daughter, C3, in the group intervention, raises interesting questions in light of her daughter's subsequent comment about missing her friends after a number of intervention sessions. This could be taken to mean that, while the parent favoured her daughter's participation in intervention, it was the impact on C3's social contact with her peers that mattered most. This suggests that group intervention design for anxious children should consider friendship patterns in the selection of participants. Consideration should also be given to the common characteristics between the targeted and universal groupings, so that the core learning goals, ethos and overall intervention experience do not serve to accentuate perceived differences for the participants. As an interesting aside, the voice of children has occasionally been sought in relation to design of the built environment (e.g. Ghaziani, 2008). However, comment regarding their preferences for inclusion in intervention groups, for example, in relation to the more important issue of their wellbeing, appears to be generally absent in the literature.

Parent

A spectrum of noticeable differences also emerged during the intervention in relation to parents' wellbeing and motivation for involvement. One parent acknowledged her difficulties in relation to her mental health and wellbeing stating that her daughter's absenteeism from school is a cause for concern

> *In the morning I feel totally different for the first hour ... my hormones are totally different. I just don't want to get up and no one could possibly know how I feel when I wake up. I want to turn over and go back to sleep I don't want to get up. Black, doom, gloom darkness. Negative, pessimistic yuck.*

While *FRIENDS* strongly encourages schools to enhance partnership between families and schools with the aim of developing '*strong, emotionally resilient children in the community'*, difficulties were experienced in maintaining an open and communicative relationship with this parent throughout the project. Another parent linked his daughter's anxiety to his own, stating that she reminds him of how he was as a child, very quiet and timid. A complicating factor for schools relates to evidence that the relationship of parents of anxious children with teachers can be '*quite unusual'*, making this co-operation more difficult (Kumpulainen *et al.*, 1998:28).

Economic recession has led to an increase in poor health status, raising international rates of anxiety and depression among the economically vulnerable (Quaglio *et al.,* 2013:13). In this study, one parent frequently focused on the family's financial difficulties during interviews, describing the guilt she experiences from not having enough money to give to her daughter (i.e. *'ponying up'*). 'She stated '*I beat myself up every day about this. I think I'm a bad mother and I don't deserve to have her because I'm not ponying up' (i.e. provided her with money).* This parent did not attend the Caregiver and Educator seminar before the intervention began and did not complete the research diary provided at the start of the project. '*Psychological distress among parents is often also a signal of socioeconomic adversity in the family and both are influential for children's cognitive and social development'* (Mensah and Kiernan, 2010:1032). This interplay between mental health of parents, the family's socioeconomic resources and their children's development, has relevance in this discussion about the cognitive-ecological context of school.

This study also included parents whose actions during the intervention showed their support at every turn. They encouraged their daughter to share one specific family interest with the

group, and were generous with their time in relation to the project. Parental involvement has been shown to be a key protective factor that fosters cognitive and emotional resilience when people are faced with stress (Waanders *et al*., 2007). Gaining parental involvement in school health education, however, has proved challenging (Inchley *et al*., 2006). This is noteworthy in light of findings that economically disadvantaged children are especially at risk for the development of mental health problems, because of the greater number of risks they are exposed to (Keenan *et al.*, 1997, Lavigne *et al.*, 1998).

This spectrum of differences among parents was distinctive, and is a complex challenge for practitioners engaged with anxious children. Therefore, it may be necessary for EPs to strategically articulate and build commitment differentially and individually with each set of parents in advance of intervention in order to optimise their involvement. It suggests that the heterogeneity of parents, in relation to mental health, is a crucial factor which needs to be considered when addressing the learning needs of anxious children. In my experience, schools are frequently aware at some level of issues in relation to wellbeing and economic health among a small number of parents, but are rarely in a position to have worthwhile conversations about the effects of these wellbeing issues on children.

Stigma

An ecological factor which may impact on the establishment of a targeted group for social and emotional support, relates to perceptions of learning deficit, which attach to existing school support models. Traditionally, the withdrawal model has involved withdrawing children from mainstream class to work in groups for a set period, one full term or more, to compensate for literacy or numeracy difficulties almost exclusively. A specific difficulty, such as anxiety as a basis for group work, is rarely considered due to the risk of stigma and increased anxiety. While the NEPS policy, as outlined in the *Wellbeing in Primary Schools: Guidelines for Mental Health Promotion (2014*), indicates small group support to address specific issues, I was very conscious of the risk of stigma or labelling for the intervention children within their local school and community.

Therefore, the proposal to establish a specific, targeted intervention for three pupils in a small rural school needed careful management of participant perception. In this regard, and as stated earlier, the mediating role of the principal teacher within the school community was crucial. Perhaps there is even greater potential within the principal's role for the development

of wellbeing initiatives and reducing stigma about mental health in small communities. Mayer e*t al.* (2009:198), for example, point to a potentially useful strategy of pairing mental health meetings with other '*required'* parent-teacher association meetings. This approach would serve to locate discussions about wellbeing within ordinary school business so to speak. The principal, however, would need to gain support from stakeholders (i.e. parents, teachers and management) in order for this to happen. Whether this would gain support from teacher unions is also questionable in light of comment provided earlier that *'addressing the mental health needs of youth goes beyond the purview of public school'* (Mayer *et al.*, 2009:93).

Overall, the evidence in relation to stigma in school settings is sparse and mixed. Some studies show that targeted interventions for an indicated group are more frequently associated with stigma than universal programmes in which everyone participates (e.g. Offord *et al.*, 1998). However, Rapee *et al., (*2006), found no significant differences between youth participating in universal and targeted groups. The 'two settings approach' which emerged naturally during this study's intervention, may have served to counter negative perceptions associated with withdrawal models. Weare's (2013:13) position is that any understanding of mental health depends on our values, preconceptions and assumptions about '*what constitutes normality*'.

Evidence suggests that by virtue of joining their peers in the mainstream classroom for Phases 1, 3 and 5, the likelihood of the TG children being categorised as *'a deviant and/or sad minority'* was reduced (Weare, 2000:19). Furthermore, the approach resonates with the proposal that what is needed is a move away from identification of disability and a '*careful assessment of the interaction of the student and the school environment'* (Ferguson, 2008:113). Thus, this study's 'two settings approach' may also represent more fully the bio-psycho-social framework of NEPS psychologists, which recognises social context as an influencing factor in strategically optimising learning. While such an approach would require a level of planning and commitment, underpinned by a more radical child-focus in building targeted but inclusive practices, there may be untapped benefit in it for schools.

This determination of what might work within the ecology of a school appears to align with Ainscow *et al.'s* (2006:3) views on inclusive practices which state that *'values and principles have to be enacted in particular institutional contexts'*, and that '*there can be no approach*

to development which does not involve detailed exploration of a particular setting'. Thus, EPs must take account of the social processes of learning that go on within their particular contexts for anxious children. Additionally, *'evidence-stimulated reflection'* can help a school to *'create space for reappraisal and rethinking by interrupting existing discourses, and by focusing attention on overlooked possibilities for moving practice forward'* (Ainscow *et al.,* 2006:143).The evidence for this 'two settings approach', while perhaps not explicitly articulated in any policy, emerged organically from this study. Validation for the approach was found in the words of the principal, in a discussion about whether there was fertile ground for this type of intervention, when she stated that '*there has to be a certain dynamic in a school. There has to be openness to innovation among the staff'.*

Commentary about models of support in schools has almost exclusively related to how schools select and place pupils for small group support, how it is timetabled to meet wider school needs and on when and where to offer the support. Decisions emerge from internal school conversations. Mackay (2006) states that EPs are the (mental health) professionals '*most thoroughly embedded in the educational system'. FRIENDS* is based on psychological theory the NEPS' psychologists understand. As a service, NEPS is well-placed to guide schools on the application of this psychological theory within the school context. As EPs, we could bring an external and perhaps, professionally objective voice, to an internal discussion.

The question as to whether intervention should to be delivered to mutually exclusive targeted or universal groups, needs to be addressed. One could reasonably ask whether children's needs could be met at both levels in a school. This study successfully merged targeted and universal group children for intervention. This approach had a high level of ecological validity to the extent that '*the act of researching* (and intervention in this study) *should have relatively little impact on the setting – retaining things in their natural form'* (Denscombe, 2010:90). The flexible placement approach challenges many established models of service delivery which support tiered or staged levels of intervention for distinct groups separately (DES/NEPS, 2011). Traditional models offer poor internal school placement flexibility for the learner, as under present arrangements, when a student is selected for a learning support group, that student remains a member of that group only and receives intervention in locations separate from their peers for a term or longer period, a practice counter to inclusive practice.

Small group intervention for anxious children

Support is discernible in relation to the impact of small group interventions for Social and Emotional Aspects of Learning (SEAL) in the UK. It has been evaluated as '*promising*' by Humphrey *et al.,* (2008:100), who state that small group work should have an appropriate profile within the school. It should also be noted that a key improvement in design would be to raise the possibility of flexible placements in advance with participants, in order to reduce any element of surprise which might raise anxiety. This could further improve the value of targeted, small group work for niche populations with distinctive needs. A proposal for more flexible placement arrangement for universal and target groups can be seen Table 5.1 below:

Table 5.1 Study's proposed primary school placement arrangements to optimise intervention for target and universal groups

Programme phase	**Placement arrangements for programme delivery**	
Establishment	Target and universal groups combined in setting 1 (i.e. mainstream classroom)	
Delivery phase 1	Universal group in setting 2	Target group in setting 2
Delivery phase 2	Target and universal groups combined in setting 1	
Delivery phase 3	Target group in setting 2	Universal group in setting 2
Conclusion phase.	Target and universal groups combined in setting 1	

In establishing ecologically-aligned groups, schools need to be empowered to identify and respond differentially, where socioeconomic adversity and mental health difficulties exist together. This is challenging territory for schools due to the difficulties that they may experience in identifying and effecting useful engagement with anxious or depressed parents. Schools have infrequent, direct contact-time with parents which limits their capacity to develop skilled and sensitive approaches that are needed when working in this area of health and wellbeing. The difficulty is accentuated by the need to ensure privacy and confidentiality in order to minimise inadvertent stigma when mental health difficulties are suspected (Mayer, 2009). Wellbeing-specific assessments can be administered as '*send-home questionnaires'* as part of a more general set of information forms which could help identification. Further, intervention groups at school could be given neutral names (e.g. Skill-building) *'that mask the selection criteria and nature of the program'* (Mayer *et al*., 2009:195).

It must also be acknowledged, that there are associated ethical issues in relation to a school knowing or asking questions about a family's wider health issues. One could reasonably ask whether this goes beyond the brief of a teacher, even if they are well-intentioned and focused on delivery of '*scaled-up, school-based therapeutic and social competency interventions'* (Mayer and Acker, 2009:20). It has been argued also that teachers and counsellors do not necessarily have the training and the resources to support anxious children, and that a collaborative approach between health and education agencies (e.g. EPS) in running specific group interventions is more preferable and safer (Marques *et al*.,2009).

In summary, findings in relation to how the risk of stigma was managed for the three anxious pupils were discussed. The '*two settings approach'*, where anxious children were not assigned exclusively to one withdrawal group, was proposed. There is a need for debate as to whether common settings within school can be used with anxious children in both targeted and universal group formats. The principal's role, as an advocate and manager of perception within the ecology of the children's school, was described as crucial in the establishment of more flexible intervention models. Associated ethical considerations were briefly discussed. The final section in this chapter discusses findings in relation to my practice as an educational psychologist during this intervention.

Educational psychology practice

The EP as an instrument

The five dimensions proposed by Cameron (2006) to make the work of EPs more distinctive represent a basis for self-critique in this discussion (i.e. *(i) adopting a psychological perspective; (ii) uncovering mediating/psychological knowledge to create situations with specific outcomes; (iii) creating explanatory models of complex human problems; (iv) using evidence-based strategies for change; and (v) sharing and promoting big ideas from psychology*). As I was the instrument of implementation, these dimensions relate directly to my actions using the PAR/CTG model in intervention, and also within the wider research context. The identification of optimal methods to deliver programme concepts within this community of significant variability was the challenge.

In the first of Cameron's dimensions, '*adopting a psychological perspective'*, *FRIENDS* strongly advocates a behaviourist approach. This emphasises the use of positive reinforcement (e.g. 'Thank-you for sharing your ideas on...'), and the use of specific praise by programme facilitators (e.g. 'I really liked the way you did your breathing exercises'). However, reflections on my actions at stage 4 of PAR/CTG suggest that a non-directive, person-centred approach guided my practice within the intervention group. This approach emphasises practitioner competencies and de-emphasises standard manual based interventions. Presbury *et al.,* (2007) point out, however, that those person-centred approaches are less frequently established in efficacy than other interventions. It must be realised, that in only considering the efficacy of a programme, one can neglect to examine other important process variables like relationships and motivation which are infrequently measured in quantitative experimental interventions (Pugh, 2010). Perhaps, controversially, I align myself with Pugh, who follows on this discussion by suggesting that '*psychologists nurture their own therapeutic function, rather than divesting too much energy in the delivery of simple manual protocols' (Pugh, 2010:394).*

Findings from the evaluation of *FRIENDS* by the NEPS (i.e. Ruttledge *et al.,* 2014:63) in twenty seven primary schools, indicate that teachers delivering the programme for the first time '*stuck rigidly'* to using the children's workbook and tended to work *'too prescriptively through the manual'* which acted as a barrier to working more creatively. My proposition suggesting that instrumentation with targeted groups should be anchored in practitioner-competence challenges *FRIENDS* programme guidance which locates the learning for the children within a natural, peer and experiential model. The therapeutic function of the practitioner is not specifically emphasised in the *FRIENDS* programme. I hold that the successful engagement with the programme for targeted groups is crucially dependent on practitioner-competence, and that complete intervention integrity, or fidelity to programme delivery guidance, is a '*clinical ideal'* but not practically feasible (Pugh, 201:395).

In contrast to this reported rigidity, I propose that psychologists should strive for better quality assurance. This could be achieved through developing greater understanding of how manual interventions can accommodate school-specific factors (e.g. Use of the school's pre-existing class representative approach to selecting children). Core implementation process variables, like the therapeutic relationship and children's motivation, also need greater consideration (Pugh, 2001). Additionally, it is a reasonable assumption that experienced

practitioners can more easily involve themselves in flexible and adaptive adherence to manualised guidelines than those who have only received the mandatory two-day *FRIENDS* training programme. Fidelity to programme scripts, use of workbook and completion of activities, I argue, is in fact an ideal in the context of using the programme with targeted groups where manifestations of anxiety and parental engagement are likely to be variable. Greater appreciation of practitioner-competence needs to be highlighted in the *FRIENDS* manual.

Given that all practitioners will bring their own set of skills to interventions, then one can reasonably question the broader value of this study's specific description of what I found to work, or whether these therapeutic competencies are more naturally located within clinical or counselling psychology professions. As Mason (2002:61) posited, I might get '*caught up in solipsistic activity, spinning fantasies about, for example, how sensitive and decisive I am'*. Rather, Mason (2002) argues that EPs need to validate their noticing against the experience of colleagues. I propose that the PRECISE principles offer opportunity for the development of a set of descriptors, a terminology, a language for educational psychologists to use which can help to describe their intervention practices more clearly. The language needs to be grounded in the real-world practice context of school. The compilation of a list of such descriptors could begin to address the risk that educational psychology as a profession might '*drift from the provision of therapy services'* unless core therapeutic functions are adequately described (Pugh, 2010:397).

Legislation in the UK clearly states that the identification and management of wellbeing in schools is no longer the remit of health services and that mental health is everybody's business (DfES, 2001). This is the case in RoI also. This is reflected in the recent *Wellbeing in primary schools* publication (NEPS, 2014). However, the goodwill of the teaching profession needs to be complimented with some insider know how which EPs can discern from greater engagement with specific populations like anxious children. Furthermore, '*educational psychologists are in an ideal position to support staff to understand the theoretical model and core principles that underpin programmes'* (Rait *et al.*, 2010:117). Thus, a *'distinct supervision role'* could evolve for EPs in schools in the ROI from work similar to that demonstrated in this study. The educational psychologists in NEPS could maintain a useful, professional oversight of child-focused CBI for conditions like anxiety and depression at the milder end of the spectrum of psychological difficulties.

Perfect and Morris (2011)) caution, however, that school psychologists have and ethical and professional duty to '*know their limits with respect to the competent delivery'* of mental health services in schools. The concept of school psychologists as mental health service providers has been espoused for decades, and school psychologists themselves report wanting to expand their roles into service delivery in this area. Indoe (1998) cautions that the profession should not claim competencies that it does not possess, or take on clinical responsibility beyond its remit. The practice, for example, inherent in CBT intervention of exposing a child to a fear stimulus needs careful consideration for school psychologists and teachers alike, and would, arguably, represent professional and ethical challenges for teachers in particular. There has been support for greater exposure to field-based experiences for EPs though, in their doctoral training particularly that could contribute to the development of relevant competencies (Perfect and Morris, 2011).

A critical examination of the sparse guidance available to schools in RoI to help them decide on whom to engage for mental health intervention states that *'in the event of a child presenting with mental health concerns, which are above and beyond the capacity of the school to provide adequate support'*, the school should follow its existing referral protocols to external services or a GP (Wellbeing Guidelines for Primary School: DES, 2015:21). In referencing the *'capacity of the school to provide support'* as a criteria, it is unclear whether external services to the school (e.g. NEPS) should be considered. These wellbeing guidelines also contain a useful caveat though, stating that the guidance should be seen as '*evolving'* and in need of *'adaptation in light of future new perspectives'* in mental health and wellbeing (DES, 2015:3). This may indicate that there is support for emerging school mental health models, within which EPs could play a more prominent role.

My findings support the value of story narrative as a way of mediating *FRIENDS* content. There is no claim that this element of this study is an original finding. I am proposing, however, that it has potential for broader transfer and use by EPs and teachers who are also well positioned to mediate recognised CB-based programmes. The fact that the use of narrative is natural to teachers increases this potential. Infant teachers, for example, are already skilled in story-telling and reading to children as it is core to early language and literacy development. The finding also adds to the DoH (2004b) statement that a variety of therapeutic skills is needed to support the psychological difficulties faced by children and that these include cognitive, behavioural, pharmacological and systemic. Others have

commented that specific terms like cognitive therapy (CT) may become redundant in the future when all the most powerful strategies become integrated into what is simply known as Child Focused Psychological Intervention (CFPI). Thus, Pugh's (2010) statement, that EPs' over-commitment to simple intervention protocols has undermined educational psychologists' wider role as highly skilled therapist/generalists and suggests future challenge for the profession.

Theoretical perspectives within applied practice

It has been proposed that EPs can become unconsciously attached to their own particular unfounded theoretical perspectives, and weave them unconsciously into their practice (Fox, 2011). However, I argue that this study's intervention work with such a distinctive group presenting with anxiety differed significantly from my usual applied practice activity and required a closer and more critical reflection on my intervention skills. Fox (2011:327) argues that '*EPs should become involved in different types of research to justify professional practice'*. In contrast, he proposes that EPs should build their own expertise, rather than relying on existing evidence-based practice (EBP) and becoming attached to particular theoretical approaches which may have little relevance when contexts are specific. While randomised controlled trials (RCTs) are regarded as the gold standard underpinning EBP, they are arguably more suited to medical fields and as a basis for universal treatment, as opposed to describing the needs of particular individuals in particular contexts. In my view, they offer little guidance on an important determinant of intervention effectiveness – the relationship of the psychologist to the client.

This research provided opportunity for me to examine my applied skills. In pointing out that the American Psychological Association (2006) (APA) has explicitly argued that an evidence-base not only includes research, but also professional expertise, Fox (2011) argues that practitioner research becomes a way of examining professional expertise. Psychologists can '*learn how to act as a psychologist by experiencing these unique situations and reflecting on one's own experience'*, within, what Schon has described, as '*indeterminate zones of practice'* (Schon, 1987, cited in Fox 2011:328). This emphasises the artistry as opposed to the science of the EP profession. Dutton (1995) argues that experienced psychologists will recognise patterns and will automatically 'know-in action' (Schon, 1987) and will name and frame problems in a way that indicates a solution. Different psychological theories are given their validity by the artistry of the EP in doing this. Fox (2011) points out

that it is important for EPs to know what is happening to them when they are confronted by evidence that does not fit with their chosen theoretical framework. Thus, the task for EPs is to strengthen their own evidence-base through practice-based evidence. This, in turn, can convert their experience into expertise, which can be used in these incongruous situations.

Improving my practice

On reflection, future interventions would benefit from gathering substantial, baseline data in relation to the target intervention children's approach to the management of their anxiety, and whether they rely on thinking, feeling or doing strategies. Perhaps Mayer *et al.'s* (2009:183) suggestion that '*parsing the anxious experience into these three components helps transform a diffuse experience like anxiety into more concrete and recognisable constructs'* was worth considering. In hindsight, knowledge of how the participant children in this study think about anxiety (e.g. cognitive style), how they feel it (e.g. physiological symptoms), and what they do about it (e.g. actions and behaviours) may have been useful, for example, in supporting them in the development of coping step plans. Greater prior knowledge about the children's variability in their recognition of feelings (i.e. physiological) and their ability to relax (i.e. actions and behaviours) in particular could have been used as a basis to gently prompt them to develop more self-efficacy. It could also have underpinned more formulation in advance of commencement of this study.

The limitations of what is possible within group-work also became apparent to me in light of Stallard's (2005) proposal, that in the context of clinical practice, the clinician and the child should initially develop a shared understanding of the problem. Such a formulation, where the child uses '*their own words to describe their feelings and the meanings they ascribe to events'* also seems valid in relation to this school-based work. '*Clinical formulation is at the heart of good clinical practice'* and can help the child to make sense of their difficulties and guide the practitioner in planning and delivering the right intervention while pointing towards '*the collaboratively agreed goals for therapy'* (Stallard, 2005:27). Clinical formulation therefore is a shared understanding on which to inform intervention. However, this intervention was not therapy, and as stated earlier, problem-specific formulation for individuals is not part of the *FRIENDS* group work. A more useful way for EPs to consider this issue of developing a shared understanding or formulation, is to use solution-focused discussions more strategically in advance of intervention. This could help to raise the children's awareness about their respective coping strategies with a view to

validating and enhancing them, and agreeing to bring them into greater use within group work.

Ethical considerations during intervention

Getting off to a good start was important in the intervention. However, as anxiety is an internalised emotion, it is reasonable then to ask how well-placed these children were to signal their discomfort during the early sessions, and whether the '*I want to Stop'* card served its purpose? Only one communication in relation to emotional discomfort was received during the intervention, and this was conveyed through C'3 mother. Perhaps the development of a clearer method for children to signal their levels of emotional comfort or discomfort, and what they considered to be the helpful and unhelpful elements in the programme is required. The use of TM may have some potential here.

One could reasonably ask the question: What would have happened had C1 and C3chosen to remain largely silent and their verbal output had not increased as they moved through the intervention phases? Arguably, this would have given rise to a deeper search, a more focused noticing by the EP and use of other approaches to give what Cameron, (2006) referred to as power and relevance. While the suitability of the two tools initially employed to facilitate the children's non-verbal expression (i.e. Talking Mats, MHC cards) was established through the children's immediate positive engagement with them, I could have been faced with the greater challenge of the children's non-engagement verbally, and faced with '*uncovering mediating/psychological knowledge to create situations with specific outcomes'* and of seeking *'evidence-based strategies for change'* just to effect useful engagement (Cameron, 2006:289*).* This points to the need for a higher level of practitioner skill and raises some ethical and professional boundary considerations.

The professional practice and ethical responsibilities of EPs, described by professional and regulatory bodies for the psychology profession (e.g. BPS, HCPC and PSI) are to ensure the client's safety at all times. Article 2 of The Psychological Society of Ireland's (PSI) Code of Professional Ethics is also relevant in guiding psychologists to recognise the '*boundaries of their particular competencies and the limitations of their expertise'* (PSI, 2010:9). Thus, detailed incursion into any explanation of individual difficulties given by a child during this intervention would have been professionally unethical. This concludes the discussion about my practice as an educational psychologist in which my instrumental role was critiqued and

argument made for greater description of relevant practitioner competencies for the work of EPs within specific contexts.

Conclusion

It is heartening to note, as I reach the conclusion of this work, that within a proposed recent framework of effective approaches to improve mental health outcomes in UK schools (Weare, 2015), the evidence has been brought together by Public Health England (2014) which links wellbeing learning and school improvement. '*Children with greater wellbeing, lower levels of mental health problems and greater emotional attachment to school achieve higher grade scores, better examination results, better attendance and drop out less often'* (Weare 2015). Within this framework there is argument for proactive additional work on *'targeted approaches for higher risk students, with whom interventions are likely to have the most dramatic impact' (Weare, 2015).*This chapter discussed the findings in relation to application and programming by an EP within a specific cognitive-ecological context for anxious children. In the final chapter these concepts are synthesised into a model for EPs to use in support of anxious children at school. The proposed model can begin to '*engage the whole community'* and offer voice to students in the delivery of these targeted approaches (Weare, 2015).

Chapter 6 Conclusion

Introduction

There are few, targeted, school-based responses to primary school children's anxiety. Neither has any literature been found describing how school professionals, like educational psychologists, might work within targeted group settings to support the needs of anxious children at school. This small-scale study sought to fill this gap by exploring the perceptions of participants in an intervention, using the *FRIENDS for Life* programme, with three anxious children by an EP, in a rural, mixed, primary school in the RoI. Professional practice implications for educational psychologists were also considered. The study aimed to:

- develop an understanding of the participants' perceptions (i.e. teachers', parents' and anxious children's perceptions) of the contribution of an adapted CB-based intervention (i.e. *FRIENDS for Life*) to a targeted group (N=3) of sub-clinically anxious children in primary school;
- develop an understanding of what is helpful or unhelpful in relation to reducing their anxiety,
- explore the factors which help or hinder the delivery of an targeted intervention, by an EP, to anxious children in primary school.

This study's intervention was delivered in two settings, over five phases, to the target group (N=3), and to the nine remaining children in their class grouping. The target group received a modified programme in phases two and four separately in the school's learning-support room, and were observed by the school's learning-support teacher during these phases. They were grouped with their nine peers, (i.e. The Universal Group) for unmodified intervention sessions in their mainstream classroom for phases one, three and five.

On-going specific refinements to intervention programme activities, based on findings from my PAR/CTG research model, were made to the programme activities for the target group in phases two and four to increase their participation. The data are fully grounded in the intervention and can be traced through my research records from concept back to original data which emerged from the FRIENDS sessions. The use of the study'sPAR/CTG model

was valid because core elements of the method involved *'constant comparative and your (*my*) engagement'* which occurred at all stages of the model (c.f. Figure 3.1) (Charmaz, 2014:320).

Parents and teachers were interviewed before and after the intervention. Research questions one and two explored the target group children's perceptions of the programme. Research question three explored the factors which helped or hindered me, as the school's EP, in the intervention delivery to the target group only.

The three research questions relevant to execute the aims of the investigation were as follows:

Question 1 Participants' perceptions of the intervention (Aim 1)

What elements of the intervention were perceived by the target group children as helpful or unhelpful?

Question 2. Participants' perceptions of mode of response (i.e. verbal or non-verbal) during the intervention (Aim 1)

2.1 What did the target group children perceive to be helpful or unhelpful when the intervention response mode was predominantly non-verbal?

2.2 What did the target group children perceive to be helpful or unhelpful when the intervention response mode was predominantly verbal?

Question 3. Helpful and unhelpful factors for intervention delivery (Aims 2 and 3)

3.1 What factors helped or hindered intervention delivery to the anxious target group children?

3.2 What factors helped or hindered intervention delivery with parents?

3.3 What factors helped or hindered intervention delivery with teachers?

3.4 What factors helped or hindered intervention delivery at a whole-school level?

3.5 What ethical issues arise in relation to intervention delivery at school to children with anxiety?

Main findings

Evidence to support my conclusions is based on the anxious children's written and spoken output, on the learning-support teacher/observer's recorded observations during phases two and four of the intervention, and on discussions with me immediately following the delivery of the sessions as seen in Table 3.2. Parents and teachers were interviewed using a constructivist grounded theory approach at T1 and T2. Data from my research field notes and memos written after each session with the target group, have also been used to support study findings. The study's main findings in relation to the research questions can be seen in Table 6.1.

Table 6.1 Main findings

Research question	**Main findings**
Question 1	The main finding was that the TG children showed a preference for writing and drawing during the *FRIENDS* programme activities using a study-specific, child-selected character, 'Millie'. Other findings included the following: The ideas selected by the TG children for running their group included staying silent, writing or speaking. The intervention study's '*I want to Stop'* card, available to the children during each session, was not perceived as important to the TG children. The TG children's engagement in relaxation activities varied. Role plays were unsuccessful as a pedagogical device with the TG children. The TG children's ability to accurately identify feelings, a programme element, seemed underdeveloped.
Question 2.1	Programme specific MHC cards (i.e. Hand held re-usable plastic cards used for drawing) were perceived as helpful. The use of Talking Mats as method of facilitating non-verbal engagement with the anxious children was deemed impractical after session two.
Question 2.2	The use of emoticons was deemed useful in paired work on feelings' recognition. The use of humorous guessing as a pedagogical device by the EP was evidenced as helpful.
Question 3.1	'The two settings' approach where the TG children received five of the *FRIENDS* sessions in their mainstream classroom and nine in the learning support room was evidenced as helpful in reducing stigma for the TG. The PRECISE principles proved useful in building therapeutic relationship with the anxious children.

	The leadership role of the principal was helpful in advocating for and normalising the intervention. The spectrum of the children's anxiety and silence proved challenging within the intervention.
Question 3.2	Parents' sensitivity and awareness in relation to their daughters was helpful. Some variability in parents' engagement with the researcher was noticed.
Question 3.3	The principal teacher's values, judgements and advocacy for the intervention were helpful. A slow development of therapeutic relationship with the TG children impeded the release of responsibility to the LST for programme delivery.
Question 3.4	A pre-existing school selection process (i.e. 'The class rep system') was helpful in recruiting children for the TG. The principal teacher's values, judgements and advocacy were helpful. Screening measures were evidenced as tedious at certain stages by adult participants.
Question 3.5	As an educational psychologist, monitoring the TG children's emotional comfort, while participating in intervention, was challenging.

Synthesis of findings

The aim of this study was to explore and develop understanding in relation to how educational psychologists can intervene with a target group of anxious children in school. This was considered important in light of growing concern about anxiety as a condition of childhood, (e.g. Costello *et al.,* 2003), the need to prevent further problems manifesting in adulthood (Liddle and Macmillan, 2010), its impact on school performance (Essau *et al.*, 2000), and the professional need for EPs to uncover '*mediating/psychological knowledge to create situations with specific outcomes'* (Cameron, 2006).What emerged from the fusion of findings are three concepts, which are strongly grounded in evidence from the PAR/CTG process.

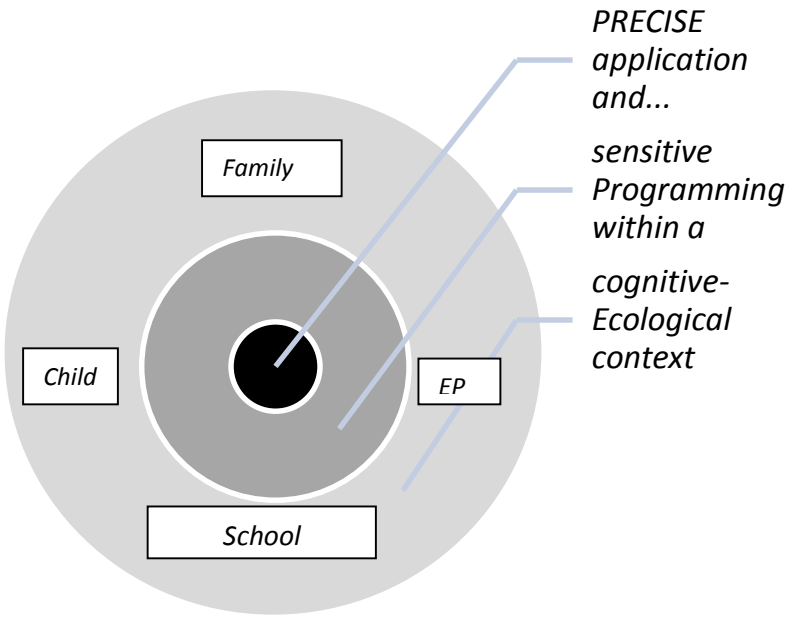
The first of these concepts refers to the cognitive-ecological context for intervention. This refers to the school within its community, its beliefs and values in relation to wellbeing and mental health. The second concept refers to the process of programming for early intervention within this specific context. The third concept which emerged from this study relates to the creative application of the decided programme elements in a way that optimises therapeutic relationship with intervention participants.

They are proposed as being crucial to EP practice with anxious children. These concepts are now combined in the conceptual framework seen in Figure 6.1. This is the study's proposal for how EPs can use the PRECISE(P) principles in applying their skills in sensitive Programming (P), within a cognitive Ecological (E) context, to support anxious children in targeted intervention (i.e. hereafter called the EPPPE Model). This three-staged model of support may have wider utility for EPs.

Study's proposed EPPPE model for educational psychologists

As mentioned earlier, the EPPPE model of intervention for anxious children (c.f. Figure 6.1) draws on Bronfenbrenner's (1979) Ecological Systems Theory which describes human behaviour as arising in the context of complex interactions between the characteristics of individuals and the environments in which they interact. The model aligns with the NEPS model of service, acknowledging multiple influences on childhood anxiety which are sought to be understood by the EP before deciding to enter into intervention with anxious children. As Ainscow (2006:3) argues, schools are '*communities of memories'* and are permeable. Thus, as professionals who visit schools, EPs have to engage with these histories if we are to contribute to institutional development. Secondly, and in relation to what Ainscow *et al*., (2006:3) refer to as *'enactment in context',* there is therefore a need for a framework or set of indicators which can guide EPs in relation to their conversations within these distinctive communities of practice. This can perhaps go some way to meeting the challenge to EPs to evidence what the most '*powerful ingredients'* are for children within their local primary school (Rait *et al.*, 2010:117).

Figure 6.1 The EPPPE model of support for group work with anxious children for EPs



The decision-making process for the EP, it is proposed, begins with a consideration of the cognitive-ecological factors in relation to the proposed children for group intervention. As posited by Abdul-Adil, *et al.*, (cited in Mayer *et al*., 2009:367).

> *When multiple influences on development can be considered and therefore varied, interventions can be designed to address multiple risk-factors, draw from multiple treatment modalities, and overlap with and relate what could otherwise be disparate intervention activities.*

Factors relevant within the cognitive–ecological context, as represented in the outer circle of the EPPPE model, relate to the individual children and their parents' predispositions, and how they are conceptualised within the nested context of school. An appreciation of the substantive heterogeneity of the target population is crucial within the ecological context. This should be coupled with an understanding of the importance of children's wellbeing by parents and teachers. Parental wellbeing, and parents' and/or caregivers' ability to support the intervention process, needs consideration. The readiness and capacity of the school to bridge the gap and reduce any perceived stigma in order to optimise participation are also vital.

Abdul-Adil *et al.,* (cited in Mayer *et al*., 2009:381) posit that *'just as cognitive development follows developmental patterns in form and substance, developmental influences are dependent on context'.* Decisions at this stage do not require the anxious children or their families to be identified to the EP but draw on the knowledge of the teacher. As such these discussions are on an unnamed basis, focused on children's needs, and aim to explore their suitability and readiness for intervention. The EP, and school-principal, need to judge whether the proposed intervention context offers potential for positive engagement before proceeding.

When it is judged that the cognitive-ecological factors are favourable, progression towards the second stage, sensitive programming, can occur. To begin, the EP encourages the school to form an intervention team comprising relevant school personnel (e.g. Designated Liaison Person for Child Protection, Principal's nominee, Learning support staff member). Care and safety protocols for the intervention, and entry (i.e. referral) and exist strategies to intervention are agreed. The children for whom intervention is considered potentially useful will have been identified through a combination of multi-informant data from discussions at school and enhanced by EP guidance. School then offers the proposed intervention support to the children's parents, and introduces them to the school's EP if they wish their children to take part. The EP subsequently engages directly with parents to build relationships, provide information about the EP's role in intervention, and ultimately seeks informed consent to include the identified children in the targeted intervention.

Home visits by the EP, I propose, would help in building these relationships particularly with hard to reach parents. As stated earlier, the teacher-parent-psychologist relationship is a valuable resource in relation to the education of parents in decision-making relating to interventions for this population (Carlson *et al.,* 2008: 368). Parental consent allows the EP greater access to information from school screening procedures about the proposed children. This can inform programming and ensure their care and safety. It also allows the EP to learn about the children's interests and learning styles, which in turn, can inform and guide the EP in tailoring programme activities for the anxious children in a similar way to the refinements made to FFL activities in this study.

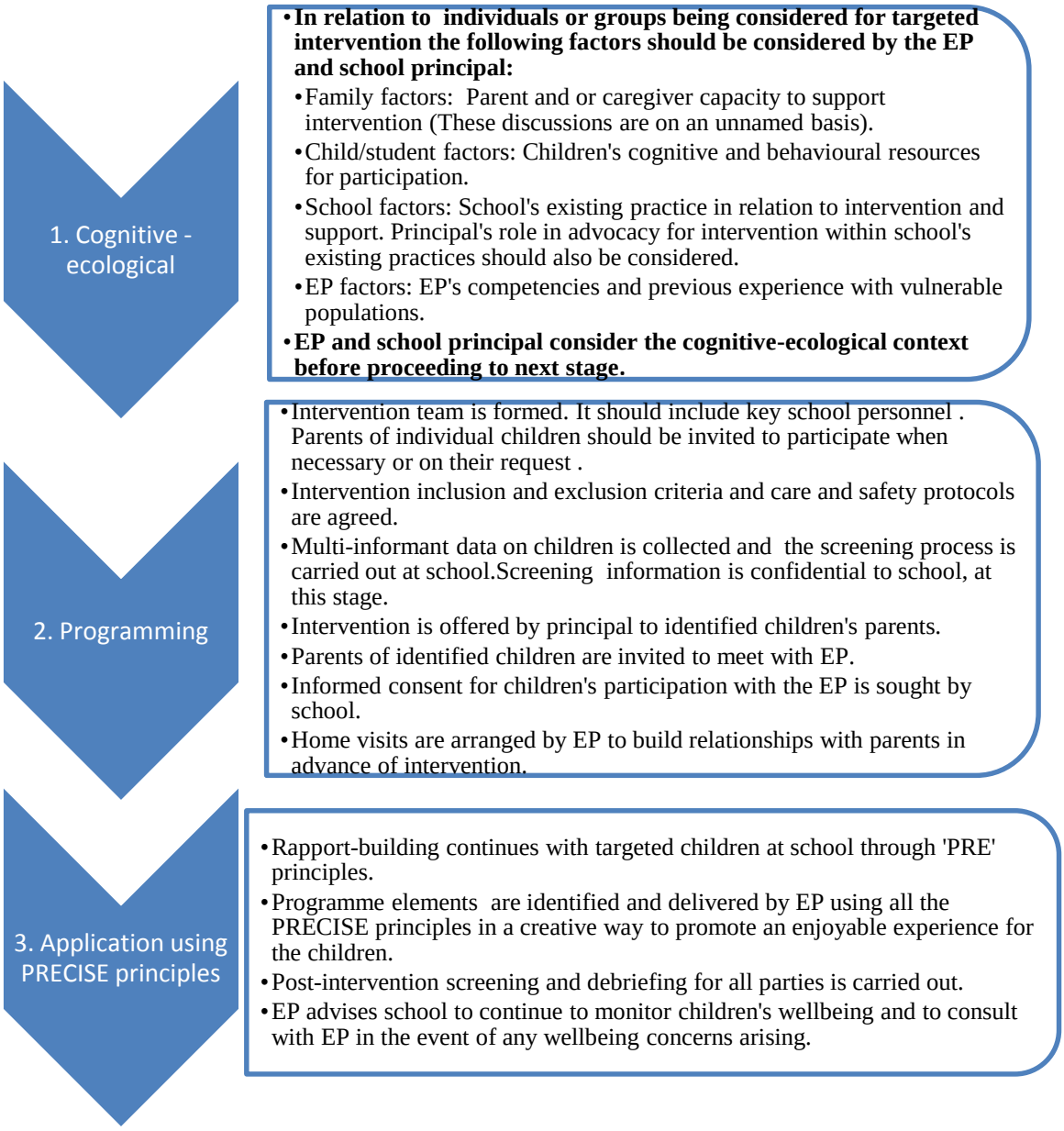
The EP subsequently meets the children and begins to address the power differential, (Christensen and James, 2000:31), build familiarity and co-ownership of the proposed intervention with them. Their informed assent to participate is crucial at this point.

'*Alongside beneficence, non-maleficience, justice and respect for persons, the fundamental principle underlying informed consent is self-determination'* (Lambert and Glacken, 2011:783) (c.f. Appendix 17 *Elements of Assent).*

Abdul-Adil *et al*., (cited in Mayer *et al.*,2009:381) point out that *'real-world practicalities'* like how to ensure rigorous fidelity, while maintaining manageable implementation within specific contexts, needs greater consideration. Good school-leadership is necessary at stage two of EPPPE in relation to grouping, timetabling arrangements, and in normalising the initiative for participants. As was found in this study, the principal can act as a useful bridge between community and child in normalising and mediating programme information to create the necessary conditions to legitimise intervention in the school community. It is acknowledged that each school will manage these processes differently. It is proposed that EPs can support these school processes by drawing on their knowledge and experience of both '*evidence-based strategies'* (Cameron, 2006), and on '*practice-based evidence'* with vulnerable children (Fox, 2011).

Application of intervention, guided by the PRECISE principles, can begin at stage three. As discussed earlier, this study's findings suggest that more specific rapport-building with anxious children needs to be integrated into an EP's practice at an early stage (Beaver, 2011). Therefore, at this stage, the three initial PRECISE principles of partnership working, (P) at the right developmental level (R) which is enjoyable (E) should be prioritised. Creativity (C) should be considered later as the EP discovers which activities and learning modalities are preferred. Processes which allow the EP to show empathy (E) and which facilitate investigation (I), self-discovery and efficacy (S) are likely to come into focus once children have begun to fully enjoy the group work and are more familiar and secure in the group environment. The process of using the EPPPE model is outlined in Figure 6.2

Figure 6.2 The EPPPE process of targeted intervention for children with anxiety.



The EPPPE model is founded on practices in this study. The model would require wider consideration by my EP colleagues before it could be formally piloted for use. Some of this study's findings have been presented at the Annual Conference of the Psychological Society of Ireland (2014) and at the Annual Conference of the National Educational Psychological Service (2014). They have been well received. It is clear to me that state educational

psychology services should strategically offer targeted intervention support to children with internalising conditions like anxiety in schools. In light of the positive impact of this work, the following recommendations are considered relevant in the context of developing the National Educational Psychology Service's capacity to offer such targeted support to school communities, which will ultimately support children's social and emotional learning and overall wellbeing.

> *Can we ever plumb the depths of a flood of anxiety in another person, especially a child, and then measure what impact we have had on the waters? The focus has to be on the quality of the relationship and on the observable impact on the young person and ourselves* (Peake, 2012:40).

The waters of anxiety are deep, but then so is the motivation of those who care and can help children to reach shallow water. Harnessing this motivation, to safely reach new possibilities with anxious children, appears too important an issue for society, through its EPs, to neglect. School offers an ideal opportunity for children to safely learn new skills for application within real-world contexts. I hope that through my participation with anxious children I have learned something of the nature of the waters of anxiety, and that my profession can draw on this contribution to knowledge.

Recommendations

In light of the findings above the following recommendations are proposed in relation to supporting anxious children in primary school:

EPs should begin to help primary schools to identify and intervene early with children whose adaptive behaviour is negatively impacted due to internalising behaviours like anxiety. In this regard the EPPPE model should be trialled and refined in the NEPS service and protocols for its application developed.

This study highlights the usefulness of engaging with the anxious children's imagination through story-writing and drawing. In particular, it is recommended that drawing and writing should be utilised more strategically with the *FRIENDS for Life* programme as a way of creating access to this evidence-based programme for anxious children.

There is a need for in-depth knowledge about the characteristics of the community within which an intervention is being planned as

> *processes that are established at local and national level ... allow for parental access to information, parental participation in schools ...must reflect a shared sense of purpose between parent and professional and must be characterised by mutual respect and a genuine willingness to share information and to negotiate openly and honestly* (Mac Giolla Phádraig, 2010:56).

This study, therefore, recommends also that EPs should visit children's homes to help to bridge any gaps in parents' understanding in relation to how anxious children can be supported. It has already been recommended that teachers *'show a willingness to engage with them in their own community settings rather than on the school premises only'* (Cooper and Jacobs, 2011:167). The introduction of a home visitation practice by EPs would help to break down barriers, and as Ainscow *et al.,* (2006:128) proposed, help to take account of social processes of learning in particular '*communities of practice'*. Within these communities *'children who are not suited to the existing menu of the school'* can provide a basis for more collaborative culture of experimentation with new responses.

Limitations to this study

A number of weaknesses have been identified with regard to the delivery of the intervention to the three target group children. Firstly, a broader range of table-top activities (e.g. drawing, board games, jigsaws), with low requirement to speak, would have been useful. They would have been helpful in building emotional comfort and co-participation during the early sessions when the children were at their least interactive with each other and me. Secondly, when story-writing about Millie emerged as the intervention group's preferred way of working, the method could have been gradually introduced to the universal group. This may have served to increase its cultural validity as a way of working, thereby, creating explicit common ground between the two groups, and possibly having a positive impact on any perceived stigma associated with participation in the group. Thirdly, despite my pre-research investment in a two-day professional training course in Talking Mats, the method proved too cumbersome to use with the group. Training in play skills may have been more beneficial.

Additionally, the role of the learning support teacher as observer was, arguably, underutilised. She could have been prompted to focus her observation on my actions as a co-participant in the intervention. This would have been helpful as an aid to my reflections at Stage 4 of the PAR/CTG process. McNiff (2002) advises that action research can involve

others as validators and critical friends during the process. In hindsight, some training for the observer may have helped to reduce any barriers, perceived or otherwise, for her making critical comments about my actions within the intervention sessions. Kemmis and McTaggart (1992) go further than this, and hold that action researchers should if necessary arrange legitimizing rituals involving consultants and other outsiders.

My aims were to sensitively explore the perceptions of the children by being a co-participant in an intervention with them in a democratic way. As I stated earlier on, I made efforts to embrace Davie's (1993) challenge to the psychological community to listen to the child from the perspective of co-participant. On reflection, however, it may have been difficult for the anxious children, within the established cultural norms of their school, to participate on a democratic, co-participant level. The school's pre-existing structures such as timetables and relationships between teachers and pupils (e.g. '*When the bell rings we have to go'*) made it challenging at times to fully embrace Davie's (1993) challenge.

Suggestions for future research

This research attempted to give voice to three reticent, anxious children in school. They proved hard to reach. Ultimately, they selected story-writing as their preferred way to engage. The National Children's Strategy (2000-2010) identified three goals crucial to supporting children's full participation in life. These state that children should '*have a voice in matters which affect them' (Goal 1),* that their lives '*will benefit from evaluation, research and information on their needs, rights and effectiveness of services'* (Goal 2) and that the children '*will receive quality supports and services to promote all aspects of their development' (Goal 3).* However, there is a dearth of research on the effectiveness of inclusive practices for particular groups of children (e.g. anxious children) (EADSNE, 2011). Therefore, further research could explore the use of the flexible 'two settings approach' described in this study in normalising targeted intervention when anxiety is indicated. This research shows that anxious children will engage when the conditions are suitable. The participation of hard to reach anxious children in similar research contexts is needed to further inform suitable interventions for them.

As mentioned earlier, research to pilot the use of the proposed EPPPE model is needed. Such research would afford EPs an opportunity for broader community contact in order to

ascertain more fully how the needs of anxious children can be met. Within the EPPPE model, the EP can act as a bridge between home and school and as such strengthen and deepen understandings in relation to the importance of mental health in the community.

A Reflexive Account

In my mind I trace the motivation for this doctoral research back a very early memory, my first day at school. As a four year old, being led up to the school door by a neighbour's older child, I felt paralysed with fear. I gripped her hand so tightly. I wanted to let go and run. Another part of me needed her assurance. Ultimately, I refused to enter on that first day. On subsequent mornings I hid behind the couch, anxiously waiting for my neighbour to arrive and escort me to school. My fear was indeed all-consuming, but thankfully subsided with time. I went on to have a pretty typical primary school education. My memories of primary school nevertheless are of social and emotional struggle.

As a twelve year old I was enrolled in a boarding school some sixty miles from home. The pattern repeated itself. I remember the fear of being asked to stand up in class to conjugate verbs in Latin: '*Amo, amas, amat, amamus, amatis amant'.* My anxiety, I sense, underpinned my compliance and my inhibited social behaviour in boarding school. I rarely broke the rules or spoke out of turn. At some stage I realised that I had specific strengths, as in my middle teens I had learned to play the guitar. I was also skilled in sports. I subsequently found a social voice and became a prefect with some responsibility among one hundred and forty of my peers. Following secondary school I attended third level education, became a primary school teacher, school principal and educational psychologist for my local schools. As I write this reflexive account, I am employed as a senior educational psychologist and manage a team of psychologists which services approximately two hundred schools. My early childhood experiences of school remain vivid, and I have no doubt, were influential in my choice of topic for this study.

I also choose to study anxiety because of one particular anxious boy, John, whom I supported as a school psychologist. For the first four years of John's primary school life he had only ever spoken in whispers at school. His teachers had described him as '*paralysed by fear'* when in class. He had described the anxiety he felt to his mother only. During meetings with his family at school his father always remained totally silent. This boy, it turned out, subsequently received a diagnosis of selective mutism, a condition which is now categorised

in DSM V as a condition underpinned by anxiety. John gave me opportunity to work on a broad canvas of maintaining factors with him. Intervention included an examination of factors relating to his family life, teachers' perceptions of him and my own skills in developing a sensitive response which also offered John a voice in his own recovery. Thus, this study was based in my personal and professional experiences.

Reflecting on the use of the PAR/CTG research model

I stood within the study's PAR/CTG research model using *'a specific philosophical stance, a particular logic of inquiry, a set of procedures, or flexible guidelines'* (Charmaz, 2014:320). I must now step back outside the research as I reach the end of my journey. To begin, I hold that the adaptation of the constructivist grounded theory method, and its combination with PAR is valid, as it was driven by clear purpose and founded on the '*untapped versatility and potential'* of grounded theory (Charmaz, 2014:337). I must now reflect in an evaluative way on where my PAR/CTG research model has led me, and on what has been gained on that journey. To do this in a balanced way, I have drawn on Charmaz's *'Criteria for Grounded Theory Studies'* (Charmaz, 2014:337). I have selected a number of criteria under each of the headings of 'Credibility','Originality', 'Resonance' and 'Usefulness'. I now present a brief discussion within Table 6.2 on each of these criteria.

Table 6.2 Researcher's reflection on the use of PAR and CTG

Criteria for Grounded Theory Studies		**Researcher's reflection**
Credibility	Has your research achieved intimate familiarity with the setting or topic?	Yes. '*We stand within our research process rather than above, before or outside it*' (Charmaz, 2014:321).The weekly coding process, on which each subsequent *FRIENDS* session was based, necessitated intimate contact with the emerging data. Memoing was a constant activity which sustained reflection and kept me involved in the analysis in order to develop the categories and ultimately the study's three concepts. The experience was very intimate and sometimes very silent. I drew on this learning as the *FRIENDS*sessions progressed and ultimately discovered a practice approach for use with anxious children.
	Are there strong links between gathered data and argument?	Yes. The data is fully grounded in the intervention and can be traced through my records from concept back to original data from the FFL session. PAR/CTG was valid because core elements of the method involve *'constant comparative and your engagement'* which occurred at Stage 3 of the model particularly (c.f. Figure 3.1) (Charmaz, 2014:320).The argument I make for a model of EP practice is grounded in my intimate experience of this case study as a participant. A significant amount of the data has been triangulated through an observer.Some theoretical sampling was achieved in the interviews with the parents and the school principal.
	Do the categories cover a wide range of	Observations could have been made in wider contexts within the school and its community. However a balance had to be

	empirical observations?	maintained in my visibility within the work with the children. Greater intrusion by me intotheir lives at school might have raised their anxiety levels and given rise to some stigmatisation. The flexibility to adjust my visibility within CTG was helpful in this regard.
Originality	What is the social and theoretical significance of this work?	There is social significance for the children. Findings evidenced the children's greater adaptability within their community. I have greater insight into the combined use of creative methods with the *FRIENDS* programme and in how to successfully build therapeutic relationship. A conceptual model for EPs to consider has been proposed. The theoretical model (c.f. Figure 6.1) will underpin my practice as an EP and will be considered when I present it at the NEPS Research and Development conference at the Department of Education and Skills in June 2015.
	Are your categories fresh? Do they offer new insights?	Fifty seven second round codes emerged, which reduced to ten themes which ultimately evidenced three main study concepts. Some of the second round codes relate to fresh territory on which no previous comment has been found in the literature. New insights in relation to how children perceived the *FRIENDS* content, how a principal teacher can act as a bridge in the community between parents and a school-based intervention and in how an EP can co-participate in intervention with anxious children have been gained.
Resonance	Have you drawn links between larger collectivities or institutions and individual lives when the data so indicate?	Some links have been drawn through the intervention model proposed (c.f. Figure 6.2). Specifically, I argue that, EPs should carry out home visits in order to build relationships with families in advance of intervention with their anxious children at school. I have outlined where this action fits into the study's proposed EPPPE model (c.f. Figure 6.2). Additionally, I have shared the study's model with the National Educational Psychological Service (NEPS).
	Do your data offer deeper insights about the lives and worlds of the participants?	Yes. I was fortunate to receive consent to *research <u>with</u> children* (Christensen and James, 2000:31) and to share intervention activities with those who have intimate knowledge of what it is like to be anxious at school. The insights I have gained suggest to me that anxious children can use their imaginations in interface with CBT content, and can draw of their ability to enjoy narrative and metaphor when doing so.
Usefulness	Does your analysis offer interpretations that people can use in their everyday worlds?	Yes. EPs can draw on the interpretative findings of this study. In particular the proposal to spend time building rapport with the intervention children through the use of the first three PRECISE principles 'PRE' (c.f. Figure 2.2) and the gauging of receptivity within the cognitive-ecological context of the school (c.f. Figure 6.1) are useful in the daily work of EPs.
	Can the analysis spark further research in other substantive areas?	There is a dearth of research on the effectiveness of inclusive practices for particular groups of children (e.g. anxious children) (EADSNE, 2011). Therefore, further research could explore the use of the flexible 'two settings approach' described in this study in normalising targeted intervention when anxiety is indicated.

The end of the research journey

It heartens me now to see that children's wellbeing is being prioritised by the Department of Education and Skills (DES). This year, for example, DES has introduced primary school wellbeing guidelines as a support for teachers and schools (*Wellbeing in Primary Schools:*

Guidelines for Mental Health Promotion, DES, 2014). Additionally, the Professional Development Service for Teachers (PDST) has seconded teachers to raise awareness in relation to the wellbeing of primary school children. I hope my research has made a useful contribution to these developments by creating new ground for professional debate and highlighting the potential of the profession of educational psychology to be helpful with anxious children.

My journey started with a tightly held hand on the way to school. It is over fifty years later now and I experience what I consider to be a normal range of anxiety. This study has deepened my understanding of how to intervene as an educational psychologist with childhood anxiety. I hope it will ultimately sharpen my practice with children in pursuit of their wellbeing.

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APPENDICES

Appendix 1 'The FRIENDS Club' information sheet for parents

My name is Adrian Gavin. I am a school psychologist with the Department of Education and Skills and a doctoral student at the University of Lincoln, UK. I work with parents, children and their teachers at your child's school. My job is to help children reach their potential as learners. Sometimes I deliver programmes which promote social and emotional wellbeing and problem solving skills that children can use in their daily lives. I am inviting you to give me permission to invite your child to participate in my research.

I am about to deliver a new programme in your school called 'FRIENDS for Life'. The programme will be delivered to two groups, a large group and a smaller group, FRIENDS Club, with just three children. You have been invited to consider allowing your son/daughter to take part in the smaller group which uses more visual methods like picture cards and symbols and is a more play-based approach to deliver the programme. Your child and others may benefit from this research.

I am funding the materials used myself. I am part-funded by the Department of Education and Skills to do this research.

What will your son/daughter do if they take part in the small group?

_____ (name of child) will work in a group with me using different materials but the content of the programme will be the same as for the larger group. In the first few lessons they learn to recognise a variety of thoughts and feelings using pictures and symbols. Later they will move on to tell the difference between helpful and unhelpful thoughts, and about how to challenge unhelpful thoughts and turn them into more helpful ones. The programme also teaches about building friendships, how to use relaxation and how to develop 'Coping Step Plans' for challenging life situations.

Another teacher will sit in the room when we are working and I will ask her to assist as I deliver the programme. Other children in the school will know the group as the 'FRIENDS Club' which practices the *Friends for Life* skills just like those in the large group, but at a different time. The sessions will last 30-40 minutes.

What's good about this project?

The 'FRIENDS' programme has proven to be effective in promoting children's emotional wellbeing and problem-solving skills. Your child has the opportunity to take part in the programme and in a small group setting with more frequent skills practice. What I learn about how the three children perceive the programme may help others in the context of my study with Lincoln University in the UK. I will take notes about how they respond as I deliver the programme. I will share what I learn with you when we finish if you wish. Your child's name, or the school's name, will not appear in any of the study documentation.

Care and Safety

A team comprising the learning support teacher, school principal and myself will oversee the project. This team will meet weekly. I will call you by phone once a week to check with you about how your child is finding the sessions and your child can be withdrawn at any time. I will also work closely with the teachers to ensure your child is happy to attend the sessions.

What will other parents know about the project?

I will meet all parents taking part in the project before it starts to tell them about how it works and about the large group and the smaller group. If something a child says in the group during the project worries me about their safety or someone else's safety, I may have to talk to the principal about it. This is to keep all children safe.

Consent: If you decide that you would like to give your child the opportunity to take part in the small group then I would like to meet with your child in the presence of the school principal on __/__/___/.

I will call to remind you about this closer to the time. You can contact me on 087 6502005.

Signed Adrian Gavin

Appendix 2 Inclusion and exclusion criteria for intervention group

Inclusion criteria (Informants are teachers, parents and researcher)

	Criteria 1	**Criteria 2**	**Criteria 3**	**Criteria 4**
Participants	**Teacher/parent information**	**Indicative Scores on SCAS and SCAS-P**	**Strengths and Difficulties Questionnaire (SDQ)**	**Scores on BASC-2 (TRS and PRS scales)**
Child 1 Moderate category with additional communication apprehension	Data showing that some anxiety is present and deemed to be moderately to severely impacting adaptive behaviour (e.g. Communication apprehension).	1 - 1.5 SD above mean.	Evidence of significant emotional distress difficulties and greater than C2 and C3.	Evidence of significant anxiety/withdrawal difficulties greater than C2 and C3.
Child 2 Moderate category	Data showing that some anxiety is present and moderately impacting adaptive behaviour	> 1 SD above mean but below 1.5SD above mean.	Evidence of greater emotional distress difficulties than C3.	Evidence of greater anxiety/withdrawal difficulties than Child 3.
Child 3 Mild category	Data showing that some anxiety is present and mildly impacting adaptive behaviour.	Between .5 and 1 standard deviation(SD)above mean	Evidence of some emotional distress difficulties.	Evidence of some anxiety/withdrawal difficulties.

Suitability for inclusion will follow an initial consideration by the school principal and the researcher of all of the above and any other relevant factors which might negatively impact a child's wellbeing. Parents' and child's consent to participate are necessary.

Exclusionary criteria:

A pre-existing diagnosis of an intellectual disability, language or literacy difficulty.

A pre-existing referral to an external clinical service.

Less than eight years of age more that eleven years of age.

Referral pathways to clinical services for further assessment and/or treatment will be discussed with parents and teachers should the need be identified before, during or after the intervention. Such a referral would necessitate exclusion from the intervention.

Appendix 3 OK Form for taking part in the '*FRIENDS* Club'

, _____ have been asked by Adrian to join the 'FRIENDS Club' at school. This means that I will work with two other children in Ms. _____'s room once every week for about half an hour. Adrian has told me it is about learning to use new skills to cope with the everyday challenges of life and that what he learns from doing the FRIENDS for Life programme could help other children.

Adrian has told me that Ms. _____will also sit in the room when we are doing our activities and that she will write stuff down about how the programme is working. Adrian will lead most of the activities but sometimes she will take Adrian's place and he will do the writing. I am happy for this to happen. Sometimes he will take photos of the symbols I use, but not of me. I can have a copy of the photos if I want one.

In the FRIENDS Club I can use pictures or write words or just point when we are doing the activities. If I don't feel like talking that's quite ok. I can take part in whatever way I choose. It's up to me.

If what we do makes me uncomfortable I can use the **'I want to STOP'** card. No one will be mad with me if I decide to stop at any time. Adrian and my teacher will talk to me in a quiet place at school at the end of the day. I have been promised that anything Adrian learns about me will be kept as secret as possible. Adrian has talked with me about this. I know that I can ask questions about the FRIENDS Club now or later at any time. I have told my parents about the FRIENDS Club and they have said that it's OK for me to take part.

I really want to help in this project. Child's signature:

Researcher's Signature: _____Date and Time:_____

Appendix 4 Principles and characteristics of Participatory Action Research (McTaggart, 1989)

Participatory action research (PAR)....

- seeks to improve social practice by changing it;
- requires authentic participation;
- is collaborative;
- establishes self-critical communities;
- is a systematic process of learning;
- involves people in theorising about their own practices and values;
- requires people to test their own assumptions, values, ideas and practices in real-life practice;
- requires records to be kept;
- requires participants to look at their own experiences objectively;
- is part of a political process (e.g. towards democracy);
- involves people in making critical analyses of a situation, research and practice;
- starts small;
- starts in small cycles;
- starts with small groups of people;
- requires and allows people to build evidential records of practice theory and reflection;
- requires and allows participants to provide a reasoned justification to others for their work.

Appendix 5 *FRIENDS for Life* programme

Concepts, Skills, and Strategies Taught	
Session 1 ***Introduction to the group and rationale:***	• Getting to know one another • Working in groups • Understanding and accepting our similarities and differences • Indentifying happy experiences (ongoing)
Session 2 ***Introduction to feelings:***	• Understanding our own and other people's feelings (empathy) • Importance of showing our feelings
Session 3 ***Introduction to body clues and relaxation:***	Feeling confident and brave • Listening to our body's clues to understand feelings • Exploring methods of relaxation – progressive muscle relaxation, deep-breathing, using relaxation scripts, the importance of rest and quiet time • How to feel good and help other feel good
Session 4 ***Helpful (green) and unhelpful (red) thoughts:***	• Understanding how thoughts and feelings affect behaviour • Identifying unhelpful and helpful thoughts • More on relaxation
Session 5 ***Changing unhelpful thoughts into helpful thoughts:***	• Challenging/replacing unhelpful thoughts • Thinking in positive, helpful ways
Session 6 ***Introduction to coping step plans:***	• Exploring ways to cope with difficult or challenging situations • Practice using coping step plans (breaking down a difficult task/situation into smaller manageable steps)
Session 7 ***Learning from our role models and building support teams:***	• Understanding the importance of role models and support teams • Establishing personal role models and support team • Being part of someone else's support team
Session 8 ***Using a problem solving plan:***	• 6-block problem-solving plan: identifying the problem and possible solutions, listing possible consequences, picking the best solution, putting the plan into action and evaluating the results • Group problem-solving
Session 9 ***Using the FRIENDS skills to help ourselves and others:***	• Being proud and rewarding ourselves for trying • Practising praising • Attention training
Session 10 ***Review and celebration!***	• Preparing for future challenges • Remembering the FRIENDS plan • Sharing 'positives'

Appendix 6 Session 2 *FRIENDS* Club

	Activity	Time	Script	PRECISE	Details
1	Establish agenda Warm-up activity Review Home activity Write agenda on board	5	My happy thing this week. Leader shares a happy event or experience using the MHC card. We will begin all our sessions together every week by remembering something that was fun for you recently. You can draw a picture about the event on your own card if you like and I, or another person in the group, will guess what it is. You can tell me whether I'm right by nodding yes or no. You can also speak your happy thing. It could be about your pet, your sport, something pleasant or good that happened in your family or in your neighbourhood. Leader guesses and makes some silly guesses. Others guess. Stress the point that paying attention to positive events can improve our mood and how we feel.	P E	Use Cards
2	Review Session 1 Rules and first letter	10	Last week we made a list on our TMs In session 1 we learned how to use our Talking Mats and you were able to share with the group your likes and dislikes about school. We also made a list of ideas that could help us to have fun in the group. We also played the 'Guess what I'm feeling game' Today we are going to focus more on feelings and start our display board. (1) Hand out Letter F to colour in. All share in colouring it in and arranging display board.	P	Mount rules.

			I also said that I would have the ideas you ranked for making the group a place to have furn.		
3	Individual TM	10	Investigation about Group work.	I	Participants place symbols on the TM
4	Visualisation		Today we're going to move on with our relaxation practice and to start with we are going to see how many nice pictures we can bring into our minds. Close your eyes and imagine five scenes that you find peaceful. Write some words to describe each of the scenes. Now arrange them in descending order on your 1 to 5 scale on your TM where 1 is the most peaceful and gives you a lovely feeling.	E	*'Imagining Pleasant Places'* sheet.
5	Relaxation	5	Relaxation exercise using one of your places.	E I	Check to see what place they used.
6	Understanding feelings **Role play** with feelings cards. Aim: Understanding feelings.	10	Role Play Game (Modelled by EP) Player A starts and chooses a card from the feelings card box and tries to imitate the same feeling using their face, body language, hand gestures. Player B gets two guesses to identify the feeling. Player B then gets a turn. Player A or B can use the small feelings cards when guessing he feelings.	C	
7	Let's **talk** about FEELINGS Aim: To orient the participants to the topic for the day and to build feelings **recognition** skills. It is what we do with the feeling	10	(2) *Feelings Cards Now let's look at some pictures of children. You can guess what they might be feeling. Select Image or say a word. Can you **guess** what might have happened to them to make them feel this way? What could they **do** to cope with this feeling? *Need cards for coping skills.	S I	

	that matters most.				
8.	Relaxation in different position.	5		E	
9.	Home activity	3	Share a relaxing activity with your family	P	

Appendix 7 My Happy Card (MHC)

Appendix 8 Talking Mats- Effectiveness Coding Framework

Talking M

Things to watch out for— Talking Mats Principles	
Non verbal communication	
Open/closed questions	
Pointing method	
Use of Mid point	
Who has control	
Language level	
Consistency of language	
Timing	
Method of confirmation	
Identifying factors to submat	

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Appendix 9 Symbols/emoticons

Appendix 10 Second round focused codes and definitions

2nd round focused code	Definition	**Research question**
Anxiety identification	Refers to teachers', parents' or my judgements of the presence of anxiety in the children.	3.1U,1.1U, 3.3H, 3.3U
Barriers to support	Indices of any factors which are perceived as impediments to the provision of support for anxious children (e.g. Stigma).	3.4H, 4.1U, 4.4h, 3.2H
Care and Safety	Indices of actions which would heighten the children's anxiety during the intervention.	3.1U/H,1.1U, 3.2U/H, 3.3H, 3.4U
Child's interests	Indices of topics evidenced in children's verbal and non-verbal output.	1.1h
Child wellbeing	Evidence of intervention impact on overall wellbeing of child.	
Children's participation	Observations of children's actions during intervention and parents and teachers' views of this participation	1.1H/U, 3.1H, 3.4?
Children's perception of FRIENDS programme	Evidence of a like or dislike for the FFL programme elements.	1.1H
Children's awareness	Evidence in relation to children's awareness of their own anxiety.	3.3H.1.1U
	Participants' description of any changes in the children's relationships with their peers and adults.	1.1/3.1

Children's relationships		
Classroom management	Evidence of pre-existing teacher's classroom management practice in relation to anxiety	3.1.H, 3.3H, 3.4H,
Establishing rationale	Evidence of actions which served to explain the relevance and usefulness of the FFL programme to participants.	3.4H
Family similarity	Evidence of parents identifying similar anxiety traits in their wider family as in their anxious child	3.2H
FFL programme	Evidence in relation to children's perceptions of the FFL programme concepts and activities (e.g. role play, goal setting).	1.1U/H, 3.1U/H,3.3U/?,4. 3H, 3.5U/H,
Friendship	Evidence of importance of friendships to target group children in relation to participation in the intervention.	3.1H, 3.2H
Increased confidence	Evidence of uptake of FFL activity and use of materials during session.	2.1H, 3.1H,3H
Normalising	Evidence of adult participants' actions which served to establish and maintain the intervention alignment with existing school and community practices.	3.1H, 3.2H, 3.3H, 3.3U
Non-verbal participation	Evidence of children's engagement with intervention activities requiring little or no speaking.	3.1H,

Parent as advocate	Evidence that parents are providing positive support for children's development.	3.2H, 3.2U
Parent as negative model	Evidence of parent actions which could be perceived as a negative example of wellbeing to their child.	3.2U,
Parent as positive Model	Evidence of parent actions which could be perceived as a positive example of wellbeing to their child.	3.2H
Parent judgement	Parents' judgement in relation to their child's anxiety	3.2H
Parent supporting project	Evidence from parent comment which supported the targeted intervention work in the school.	3.4H
Parent/child relationship	Evidence of discussion between child about coping strategies	3.4H
Parental wellbeing	Evidence from parent comment of in relation to their own health and wellbeing issues	3.2U
Parents' awareness	Evidence of parents' awareness of their daughter's wellbeing	3H, 4.2H
Seeking insight	Evidence of participants' reflection of ways to understand and cope with anxiety.	3.2H, 3.3H
Parents' sensitivity to difference	Evidence of parents' knowledge of their daughters' unique differences .	3.1U, 3.2U/H,

Parents' values	Indices of what parents value in their approach to parenting.	3.2U/H/?
Relaxation	Indices of helpful and unhelpful factors during the intervention in relation to children's relaxation	11.H, 2.1H, 2.2H, 3.1H
Programme concepts	Indices of helpful and unhelpful factors in relation to specific FFL programme concepts (e.g. goal setting, red thoughts green thoughts).	1.1U/H, 3.1H, 3.4U/H,
Physical elements	Helpful and unhelpful factors in relation to physical environment for the intervention and the children's use of this space	3.1H
Programme delivery	Evidence in relation to timing, materials used and associated challenges in delivering the FFL programme to the targeted group	3.1U/H/?,3.5?
Research process	Evidence in relation to the helpful and unhelpful factors associated with carrying out research with three anxious children in primary school.	3.1?/U/H, 3.2H, 3.3U, 3.4U
Researcher reflection	EP's reflections through memos and field notes between sessions as part of the PAR process	3.1U/H, 3.4H,
School management	Evidence in relation to helpful and unhelpful factors at school management level in relation to anxiety.	3.3U
School openness	Indices of school's willingness to embrace the challenge of responding to the needs of anxious children.	3.4H

School related anxiety	Indices of participants' anxiety linked to all aspects of school.	3.2U/H, 3.3h
Screening process	Evidence in relation to helpful and unhelpful factors associated with the identification of children through school-based screening.	3.2H, 3.3U, 3.4U
Social connectivity	Evidence in relation to target group children's interactions with their peers at school.	3.1
Stages of change	Evidence of target children's readiness for change as indicated in their writing. Prochaska's (1992) Stages of change model explored in this study refers only to the pre-contemplation and contemplation stages of this model.	1.1H
Support for program	Comment from participants which show support for FFL programme	3.1H
Teacher as advocate	Evidence of school principal's taking school-based actions to protect, encourage and respond to the needs of anxious children.	33H, 3.2H, 3.4H,
Teacher communicating with participants	Principal teacher's communications with children and parents in matters relating to do with wellbeing.	3.2H, 3.3H
Teacher judgement	Evidence of principal teacher's judgements in relation to anxiety and school.	3.4H, 3.2U,3.4U, 3.5U
Teacher valuing	Indices of principal's teacher value system in relation to intervention for anxiety.	3.3h, 3.4U/H
Teacher monitoring	Evidence of teacher maintaining oversight of children's anxiety levels.	3.1H, 3.4H

Teaching anxious Children	Evidence in relation to principal teacher's pedagogical approach to anxious children.	3.2U/H
Therapeutic relationship	Evidence in relation to the creation of a sense of hopefulness through application of the PRECISE principles, (which follow this focused code), where both the EP and the target children were willingly engaged in learning from their experience of the programme together.	3.1U/H/?
Partnership	Evidence of EP and children having an agreement regarding participation (e.g. how to stop participating) and evidence of working to completion of same activity during the intervention	3.1H
Right developmental level	Evidence in relation to whether the materials and pedagogical approaches were matched to the needs of anxious children.	1.1H, 3.1U/H, 2U
Empathy	Evidence of moderated actions suitable for anxious children in a small intimate setting(e.g. gentle voice, showing interest in their drawing).	1.1H, 3.1H
Creative	Evidence of impact of adaptation of FFL programme to needs of anxious children.	3.1U/H, 3.4H, 1.1H,
Investigation and experimentation	Evidence of observations of target children taking more risks and moving outside their previously observed comfort zones.	3.1H
		1.1H,

Self-discovery and efficacy	Evidence from children's output and parent and teacher comment of behaviours relating to positive engagement with the programme for improved coping.	
Enjoyable	Evidence of children's response to materials presented (e.g. MHC cards) the EP's and their own intervention actions.	3.1H,.2.2U, 1.1H, 2.1H,3H, 3.3H
Universal simultaneous to targeted	Evidence of difference for target group children's learning in these different settings.	3.4U/H
Verbal output	Evidence from observations during intervention of target group children's increased speaking behaviour	1.1H, 2.1H
Visualisation	Indices of children's use of images in the context of relaxation	2.1H

Appendix 11 Doing an Intensive Interview (Charmaz 2014)

1. Listen, listen and listen
2. Try to understand the described events feels from the participants point of view, not your own
3. Aim to be empathic and supportive
4. Build trust
5. Encourage your research participant to state things in his/her terms not yours
6. Let the participant explore a question before you ask a more specific question
7. Ask the participant to elaborate , clarify or give examples of his or her own views
8. Be sensitive to the participants non-verbal response to you and your questions
9. Be willing to take time for an issue that might come up
10. Revise a question that doesn't work
11. Leave the participant feeling positive about the interview experience and self
12. Express your appreciation for the opportunity to talk with and perhaps get to know him or her.

Don't s

1. Interrupt, interrogate, correct or confront
2. Don't rely on do you did you constructions (Too closed)
3. Don't ask why..rather tell me about, could you tell me more about
4. Don't ask loaded questions...frame questions neutrally.
5. Don't take an authoritarian stance
6. Don't ignore what they want to talk about.
7. Don't forget to follow up
8. Don't shorten the interview just to get it over with
9. Leave if someone is distressed.

Appendix 12 Ethical approval form (Form EA2)

EA2 **Ethical Approval Form:** **Human Research Projects**	**Please word-process this form, handwritten applications will not be accepted**	UNIVERSITY OF LINCOLN THE GRADUATE SCHOOL

This form must be completed for each piece of research activity whether conducted by academic staff, research staff, graduate students or undergraduates. The completed form must be approved by the designated authority within the College.

Please complete all sections. If a section is not applicable, write N/A.

Name of Applicant	Adrian Gavin	
	School: CERD	College: University of Lincoln, UK.
2 Position in the University	Postgraduate Ed. D student	
3 Role in relation to this research	Primary investigator	
4 Brief statement of main Research Question	The perceptions of anxious primary school children, their parents and teachers, of a targeted intervention based on the 'Friends for Life' programme	

5 Brief Description of Project	**Introduction** A targeted intervention (i.e. 'The small group') based on the *FRIENDS for Life* programme (hereafter termed 'FRIENDS') will be delivered over a ten week period to three anxious children with communication apprehension, in a small, (i.e. 55 children on roll), mixed, rural, three-teacher primary school in county Mayo in the west of Ireland. The intervention will constitute part of the researcher's normal work as an educational psychologist (EP) with the National Educational Psychology Service (NEPS) in the school. The FRIENDS programme will also be delivered to a whole class grouping (i.e. 'The large group' or universal intervention) around the same time to help normalise the intervention within the school for the three participating anxious children. The intervention merges the content of the FRIENDS programme (i.e. Appendix 1) which is a cognitive behaviour (CB) based programme to build resilience and coping strategies, which has World Health Organisation sanction, with elements of the Talking Mats (TM) (Appendix 2) method. This is an alternative augmented communication (AAC) approach in which symbols and pictures are used to facilitate non-verbal communication. It is hoped that the symbols and pictures will increase access for the children with communication apprehension to the strongly supported FRIENDS programme. The researcher has been trained in both FRIENDS and TM. I**ntroducing the FRIENDS programme in a small rural school** Consent will be sought initially through the school principal from the school's board of management (BOM), and subsequently from parents, teachers and children for participation as follows: **Initial meeting with parent** An initial meeting of parents of middle and upper class children (i.e. 8 to 12 year olds. N=35 parents) will be convened at school to fully explain the FRIENDS programme and its alignment with the existing Social and Personal Health Education programme in the school. The proposed two modes of programme delivery will be explained (i.e. large and small intervention) groups) and the project team (i.e. The researcher, school principal and class teacher (CT), and learning support teacher (LST)) will be introduced. It will be explained that the small intervention group will be called the 'JK Club' as the children will use 'Jigsaw Kids' (Cardboard cut outs on which pictures and symbols can be placed). All children's participation will be based on parental consent. Some additional information will be provided about the small group and the JKs and symbols will be demonstrated. Parents will be invited to give consent for their children's participation only in the large group at this meeting. It will be communicated that school will invite some parents to consider their child's participation in the 'JK Club' when initial screening has been completed. Consent from parents will cover consent to use screening measures (c.f. Appendices 6, 7, 8, and 22) and consent to participate. **Identification of children for the intervention group through screening** All children in the middle and upper classes will be screened by their teachers using the Spence Children's Anxiety Scale (i.e. a self-report anxiety scale widely used within NEPS as shown in Appendix 6).Communication apprehension forms (c.f. Appendix 7), The pragmatic Profile of Everyday Language (c.f. Appendix 8) and the Strengths and Difficulties Questionnaire (c.f. Appendix 22) will be completed by the class teachers for some children considered to show signs of reticence about speaking in school.

	The researcher will only know the children by numeric identifier at this stage (i.e. Child 1, child 2)**.** The inclusion criteria as set out in Appendix 11 will be used by the principal and researcher to determine eligibility for the intervention group -'JK Club'. This group will receive the FRIENDS programme and will take part in the researcher's study and using the 'JKs'. The large group will not. **Invitation to take part in the 'JK Club'** When eligible children (i.e. children meeting the inclusion criteria) have been identified by the principal and the researcher for the proposed intervention, their parents will be verbally invited by the school principal to meet the researcher and the 'The Jigsaw Kids Club' information sheet for parents (c.f. Appendix 12a) will be shared with them. All matters about the 'JK Club' intervention will be explained and consent sought for the school principal to invite their child to take part in the 'JK Club'. At a subsequent meeting with the child the researcher will share the children's project information sheet (c.f. Appendix 14) and seek the child's assent (c.f. Appendix 15). **Initial meeting with children from middle and upper grades** A meeting will be convened of all middle and upper grade children and the programme will be introduced by the school principal and researcher to the children in order to normalise its use and reduce any stigmatisation which could arise depending on group assignation. **Running the intervention** The school's assigned learning support teacher and class teacher s will be given training in the intervention before it begins. The researcher will adopt a participant action researcher (PAR) stance and use fun, play and humour to optimise enjoyment for participants. School like exercises (e.g. writing/reading/) will be de-emphasised. Ten intervention sessions will take place, one a week for the larger group who are not a part of the study, and one a week, running one week later, for the 'JK Club' group. This is to allow the researcher to identify helpful programme implementation strategies when giving the programme to the large group which can then be used in the JK intervention group one week later. Generally the same skills will be practised in both groups with differing materials and more frequent, small group practice for the intervention group. All intervention sessions will last approximately 30-40 minutes. In the first number of intervention group sessions the development of rapport will be prioritised to alleviate any anxiety. Learning how to use the symbols to access the FRIENDS programme and to communicate thoughts and feelings using the symbols will also be prioritised. No pressure to speak will be applied. Each child will customise their own 'JK' and use it to carry symbols relating to programme content (i.e. helpful and unhelpful thoughts and coping strategies). Children who do not wish to talk will be encouraged to use symbols (i.e. small cards carrying symbols emotions, ('being brave'), an object, an action etc) to indicate their engagement with content (e.g. their choices, views about school, communication challenges, approach to relaxation, problem solving etc.). Skill practice (i.e. breathing techniques for relaxation, developing coping step plans) will form part of the intervention while the children are with the two adults in a learning support room in school. The researcher and LST will participate in all activities as much as possible.

	In the intervention group children will work in varied ways (e.g. with their JK only, paired with another child, paired with the researcher, all three together in a group). The children will work at two different locations within the 'JK Club' room. At Desk A location the activity will be with the 'JKs' and at Desks B or C the activity will relate to interpersonal skill practice only. This is to help the participants prepare for skill generalisation elsewhere in the school or outside of school with others. In line with the delivery guidelines for the FRIENDS programme three parent meetings in total will be held with all of the children's parents (i.e. Pre, interim and post meetings for large and small groups) in order to guide them on ways to reinforce the skills learned during the intervention. **The roles of the Learning Support Teacher and Class Teacher** The LST will be present in the room during all intervention sessions. During the early sessions she will sit at a distance from the researcher/child, child/JK and child/child interactions and observe the researcher implementing the programme. She will take notes (i.e. memoing as used in grounded theory). Training for the LST will be provided on this process. Pre and post measures of anxiety, adaptive behaviour through the SDQ, communication apprehension, memos made by the researcher and the LST, comment from and observations of the class teachers, children and parents will provide rich data which will be gathered. Grounded theory will be used to guide the programme design delivery following session 1. The data from the interactions during the interventions will be analysed using a grounded theory approach. A gradual release of responsibility (GRR) (Pearson and Gallagher, 1993) is planned by the researcher to the LST in line with the schedule in Appendix 5 as the programme progresses. At a point during the final 3-4 sessions, when the responsibility for programme delivery is gradually transferring to the LST, the researcher will take responsibility to observe and memo. **Project completion** Post intervention measures (i.e. SCAS/The Pragmatics Profile/ Modified PRCA 24/SDQ) will be administered by class teachers. FRIENDS programme completion certificates will be awarded to all participants of the large and small groups. Monthly follow up care and safety meetings will be held until the end of the school year. A project review meeting will be offered to the school at the end of the project.	
	Approximate Start Date: January 2014	Approximate End Date: June 2014
6 Name of Principal Investigator	Adrian Gavin	
	Email address:	Telephone:

or Supervisor		
7 Names of other researchers or student investigators involved	**xxxxxxx (School Principal)** **xxxxxxxx (Learning Support teacher)**	
8 Location(s) at which project is to be carried out	Co. Mayo, Ireland.	

Appendix FORM EA2 Ethical Approval

9 Statement of the ethical issues involved and how they are to be addressed – including a risk assessment of the project based on the vulnerability of participants, the extent to which it is likely to be harmful and whether there will be significant discomfort.	**Boundaries of professional practice** In carrying out this intervention the researcher is working within his field of professional competence as an educational (i.e. school-based) psychologist for the National Educational Psychology Service (NEPS) in Ireland. Additionally he has received specific training and certification through his employer for the delivery of the FRIENDS programme. He has personally sourced training in the use of the Talking Mats method which facilitates the use of symbols in this intervention (copies of relevant certificates can be provided. The researcher as a psychologist is a registered member of the Psychological Society of Ireland (M1878) and The Health Care Professionals Council UK (HCPC PYL 24692) and is professionally bound by their respective codes of professional conduct. The delivery of targeted interventions in the area of mental health is a NEPS service priority. NEPS' policy is that ethical approval must be indicated from the University of Lincoln prior to an application for NEPS research approval. This approval will be sought through application to the NEPS' Research Advisory Committee which advises its Internal Management Group which ultimately gives the permission to proceed.

(This will normally cover such issues as whether the risks/adverse effects **associated with the project have** **been dealt with and whether the benefits of research outweigh the** **risks)**	The research will follow Ethical Guidelines for Educational Research, published by British Educational Research Association (BERA) (2011). It will also follow the University of Lincoln's guidelines for research carried out with humans. The consent of all parents of middle and upper grade children to take part in the FRIENDS programme will be sought at the initial group meeting with parents using the generic consent form attached to the FRIENDS programme (c.f. Appendix 13). However, additional consent will be required from parents for the three children who will be invited to take part in the smaller 'JK Club' intervention group. The following refers to the issues and processes which will be considered in gaining such consent from the three intervention children. It also considers issues in relation to their care and safety during the intervention. **Stage 1. Screening and parental consent** The intervention children's participation in the research is dependent on the consent of their parent (s) in the first instance as adult gatekeepers (Hutchfeld and Coren, 2011). No child will be invited to take part in the small group intervention in advance of this permission. Following the identification of three suitable children for the small group intervention using processes outlined above (i.e. known to the researcher as Child 1,2, and 3) the principal will invite their parents to meet with the researcher through a letter which will be provided by the researcher('Letter to Parents' Appendix 12). The letter explains the project and invites each parent to discuss the project with the researcher privately at a location of their choice. At this meeting the project will be more fully explained and the consent document (c.f. Appendix 15) to be used to gain children's consent will be shared with them. The parents will be guided on when and how to explain any additional information about the project to their child. Should they give permission for their child to take part they will be invited to sign a consent form (c.f. *Parents' Consent Form* Appendix 13).The children's consent/assent will be sought next at Stage 2. **Stage 2 The informed consent of each child.** *'Alongside beneficence, non-maleficience, justice and respect for persons, the fundamental principle underlying informed consent is self-determination*. (Lambert and Glacken, 2011, 783) The class teacher will privately explain the project to each child proposed for the intervention and invite them to meet individually with the researcher and their teacher after school on an assigned day for an information sharing session. This meeting will be signalled by telephone to parents in advance. At this meeting the researcher and school principal will share with the children's the project information sheet (c.f. Appendix 14). This information sheet and other documents used with the children will be written in developmentally appropriate language using enlarged print (14) and incorporate diagrams and pictures to convey the purpose and nature of the study. The project's risks and benefits, confidentiality and privacy arrangements, the option to

	withdraw, child protection issues and researcher contact details will be included. The principal, who has an existing relationship with the children, will help the researcher to judge whether the children are fully informed and capable of giving their assent (i.e. agreement) to participate. Elements of Assent (Lambert and Glacken, 2011) which will be considered include: A: Assess child's capacity/ readiness to assent within a context of rapport building. S: Supply the child with adequate and comprehensible verbal and written information. S: Search for signs of refusal (subtle or obvious) and ensure no pressure is applied. E: Evaluate evidence of the child's understanding through questions and feedback N: Negotiate assent continuously. T: Time is allocated to the child to think about whether to participate, or not. *'Some children suffering from fearfulness or anxiety are difficult to form rapport with'(Jones, 2003:45).* A number of implications for practice with anxious children arise and these include a very basic essential of knowing as much as possible about the psychological condition before engagement. This information will be sought form parents in advance. Jones advises that it is best to be gentle, yet clear and sensitive to the effect of eye-contact. It may be difficult for disturbed children to tolerate direct eye-contact. It is necessary to go at the child's pace. The researcher will maintain an awareness of the following core professional skills and qualities to communicate effectively with children which include: Listening to the child Conveying genuine interest Showing empathic concern Showing understanding Showing emotional warmth Showing respect for the child Showing a capacity to manage and contain the discussion Showing an awareness of the entire transaction between the interviewer and child Using suitable communication methods. Symbols can be used to facilitate communication at this stage if necessary. The teacher and researcher will have explained the FRIENDS programme and the 'Jigsaw Kids' project to all middle and upper grade children and this should help to normalise the project for the intervention group children within the school. Should the children raise the question 'How should I explain the project to the others in my class or in the school or outside of school?' then the teacher,

	the researcher and the children can draw up a short verbal script to use. The children's activities in the 'JK Club' during the sessions will be explained in terms of practising skills and using symbols to show their preferences. The different locations for the different types of activity will also be shown in advance (i.e. Locations A, B and C) With these reluctant or uncommunicative children Jones (2003) recommends allowing additional time and even several rapport - building sessions. Readiness to participate will be judged by the teacher, researcher and parent in advance of beginning any intervention work. Competence, information and voluntary-ness will form the three key elements in the decision between the teacher, the child and the researcher as to whether the consent of each child is valid at this stage. Should the child's consent be judge to be valid then the '*O.K.- Assent Form for Children'* (c.f. Appendix 15) will be presented and explained , and the child will be invited to sign to indicate their consent to participate in the 'JK Club' This consent to participate will be viewed as an on-going process and not viewed as a mere one off event. In this regard verbal assent will be renegotiated on a sessional basis in an informal manner (e.g.' Hi Mary. How are you keeping? Are you happy to stay and take part in the JK project today?'). It is important to close the information sharing session(s) well and not to end in disarray. **Each child has a right to withdraw** Children will be told that the decision to take part is theirs alone and that should they wish to withdraw from the project at any time that this is 'OK', and that 'no one will be mad with them'. They can withdraw at any time by saying so or by raising the 'I want to take a break' card which will be available at all times on their desk beside their 'JK'. In any such case where a child withdraws the researcher and the teacher will, as soon as possible and in private, discuss whether any of their actions (i.e. the teachers' actions or the researcher's actions), event at school or elsewhere has contributed to the decision to withdraw and whether a change in approach might help the participants to continue. In most cases though the researcher will quickly accept the participant's decision to withdraw and no pressure to continue will be applied. **Monitoring the wellbeing of each child using the school-based project team's 'The Care and Safety Review' process (c.f. Appendix 19)** Anxious children could be described as vulnerable. EP/researchers need to be aware of their '*possible heightened emotions'* and to collaborate with others to suitably individualise intervention programmes (Cleave, 2009, 245).

	Ethical practice for this study will comply with Article 3 of the United Nations Convention on the Rights of the Child (UNCRC) which requires that in all actions concerning children, the best interests of the child must be the primary consideration. Any emerging dilemmas or difficulties, that arise will be managed within a dual strategy of firstly the application of relevant ethical guidelines, and secondly through the researcher's responsibility to be constantly sensitive and reflexive as a researcher. *'Ethical research with children requires that researchers adopt open communication with child participants (who may be unsure or confused about how to respond to being treated as competent social actors) and critical reflexivity toward all aspects of the research as it occurs.'* (Freeman and Mathison, 2009, 70). Other strategies to enhance the children's comfortable and voluntary participation which will be used include: Asking the child to say 'Pass' if they do not want to answer a question. Asking the child to hold up the 'I want to take a break' card to go to the toilet, or request some time out or stop. Encouraging the use of a green card can be used to show that they are ready to re-join and take part again. Observing subtle changes in a child's behaviour (e.g. Signs of tension, restlessness, non-verbal clues showing reticence or anxiety). Discussing with each parent and teacher in advance about particular indicators the child uses when stressed or anxious. This will increase the researcher's sensitivity to the relevant signs. A key element in guarding against risk (e.g. raising children's anxiety levels) will be monitoring through discussion by the school-based project team (i.e. The Project Team) comprising the researcher, the assigned learning support teacher, the class teacher(s) and the parents of the three children by invitation when the need arises as soon as possible after each session. This team will meet weekly during the course of the research. A framework to guide this weekly discussion is contained in Appendix 19 (i.e. Care and safety review protocols for 'Jigsaw Kid Club'). As per the protocol a weekly phone call will be made to each parent prior to the weekly Project Team Meeting following each session to capture any concerns about their child. Should the team decide that a child's anxiety level has increased then the researcher will desist from any further actions with the child which ensue from the research process that cause emotional or other harm. An additional meeting will then take place with parent(s) in order to decide a course of action which may include withdrawal from the project. This withdrawal will be managed sensitively and will involve the child's teacher who can play a vital role in on-going monitoring after the child leaves the intervention. Parents will be guided about access and possible referral to relevant clinical and other services which the researcher is familiar with through his daily work. Should an issue arise that raises concern about someone's safety (e.g. a child reports something that a parent is doing something that is causing anxiety or is harmful to the child) then I will raise the matter with the school's Designated Liaison Person (DLP) (i.e. A

	nominated person, usually the school principal, who has official responsibility to liaise with the Department of Health and Children about child protection matters). The decision to override agreements on confidentiality and anonymity will be taken after careful and thoughtful deliberation. Notes will be kept by the researcher of discussions about illegal or harmful behaviour and others will be advised of the researcher's decision to disclose information to the school's DLP or to the researcher's DLP in NEPS. (A copy of relevant forms is attached in Appendix 20) ***Informed consent of teacher*** In planning and implementing the research will take steps to protect the rights and welfare of all participants including the members of the Project Team. **Teachers** The researcher will ensure that the participation of the class teacher and learning support teacher is free of coercion. **Privacy** The participants will have the right to confidential and anonymous treatment of their verbal contributions and other data. These contributions will be recorded in the form of written memos (i.e. short notes) by the researcher and the LST of what they said or did. Pictures will be taken of the symbols they selected and where they placed them. No pictures will be taken of children. Their worksheets and labelled symbols will be gathered and will only contain the child's numeric identifier only known to the participants. No photos will be taken of the children. The LST will pass her memos to the researcher at the end of each session. The researcher will comply with the legal requirements in relation to the storage and use of personal data as set down in the Data Protection Act (1998). They will be told that the written raw data (i.e. The notes written by the LST and the researcher during the sessions) will be scanned and stored by the researcher on a password protected USB memory stick. All physical memos, worksheets and photos will be destroyed when they have been scanned and labelled. The participants will be told that the researcher will write a book (i.e. The thesis document) about the project for the University of Lincoln and that it should not be possible to identify which child or parent in the group said or did a certain thing during the sessions. The participating teachers will be identifiable through their positions at school. If they want to read this book this can be organised through discussion with the researcher. **Methods:** The methods employed in this intervention will as far as is practicable be child-friendly and align with children's culture in the west of Ireland and within their school. **Publication** The researcher will reserve the right to publish the research under his own name. *'Professional supervision and peer support combined with personal understanding are especially important aspects of successful practice when dealing with challenging or reluctant children' (Jones, 2003:48).*The researcher will discuss the professional practice elements of this project with

	his professional supervisor in NEPS and the research approach with his lead tutor Prof. Michael Neary at Lincoln University.

Ethical Approval From Other Bodies

10 Does this research require the approval of an external body ?	**Yes** ☐
	If "Yes", please state which body:-The National Educational Psychological Service (My employer) through its Research Advisory Committee (NEPS RAC) initially and through its Internal Management Group (NEPS IMG) which is a subgroup within the Department of Education and Skills
11 Has ethical approval already been obtained from that body ?	**No** ☐ **If "No", please state why not:-** **Approval is required from Lincoln University first.** **Please note that any such approvals must be obtained and documented before the project begins.**

APPLICANT SIGNATURE

I hereby request ethical approval for the research as described above.

I certify that I have read the University's ETHICAL PRINCIPLES FOR CONDUCTING RESEARCH WITH HUMANS AND OTHER ANIMALS

Adrian Gavin

_____ 29/10/13

Applicant Signature **Date**

ADRIAN GAVIN

PRINT NAME

FOR STUDENT APPLICATIONS ONLY –
Academic Support for Ethics

Academic support should be sought prior to submitting this form to the designated Ethics Committee within the Faculty

- ***Undergraduate / Postgraduate Taught application***

A Academic Member of staff nominated by the School (consult your project tutor)

- ***Postgraduate Research Application***

Director of Studies

I support the application for ethical approval

14/11/13

_____

_____

Academic / Director of Studies Signature Date

Mike Neary

_____

FOR COMPLETION BY THE DESIGNATED ETHICS COMMITTEE WITHIN THE COLLEGE

Please select ONE of A, B, C or D below:

☒ **A. Ethical approval is given to this research.**

Please see reviewers' comments (below) for comments and considerations.

☐ **B. Conditional ethical approval is given to this research.**

10 Please state the condition (inc. date by which condition must be satisfied if applicable)	

☐ **C. Ethical approval cannot be given to this research but the application is referred on to the University Research Ethics Committee for higher level consideration.**

11 Please state the reason	

☐ **D. Ethical approval cannot be given to this research and it is recommended that the research should <u>not</u> proceed.**

12 Please state the reason, bearing in mind the University's ethical framework, including the primary concern for Academic Freedom.	

Signature of the Chair of the designated Ethics Committee within the College

4 December 2013

Signature **Date Chair of CERD Ethics Committee**

Appendix 13 Care and safety review protocols for the 'F*RIENDS* Club'

The Project Team

The project team comprises the researcher, the learning support teacher, the class teacher, the child's parents and the school's designated liaison person, (DLP responsible for Child Protection). Everyone has an entitlement to come to the weekly review meeting which will be convened by the researcher. An agreed common written record of decisions made and the reasons for the decisions (e.g. any of a,b,c,d or e below) at the meeting will be kept by the school and the researcher. The researcher will maintain regular, weekly telephone contact with one nominated parent of each child.

Monitoring the care and safety of each child

Before the intervention begins each week the class teacher will informally check with each child by asking the question 'Are you happy to attend the 'FRIENDS Club' today? Should the child give a positive answer then the child makes his way to the intervention room.

(a) A child indicates to the class teacher an unwillingness to attend:
Should the child indicate that he/she is not happy to attend then the teacher indicates in a neutral tone that this is perfectly OK and the child remains with his/her class group. The child's response will be discretely communicated to parents by the researcher and subsequently discussed at the weekly review meeting by the team. The parents are welcome to attend. Additional information may be gently sought through the class teacher or parents from the child and adjustments made to access arrangements to the intervention. A decision on whether to invite the child to the next session will be made by the group.

(b) A child raises the 'I want to STOP' card during an intervention session.

The researcher will say: '*Ok, xxxxx wants to take a break. That's fine'.* The researcher will briefly ask the child if there is something wrong and unless the child decides that it is just a short break that is needed, the LST will then walk xxxxx to her classroom. The discussion with the child must not convey any sense of disappointment. The child's decision will be discretely communicated to the class teacher as soon as possible so as to avoid any embarrassment for the child. The child's decision will be communicated calmly to parents by telephone call as soon as possible. Additional information may be gently sought by the class teacher or parents from the child. A review meeting will be held and the parents will be invited to attend. Decisions on how to proceed will be made by the group.

At the end of each intervention session each child will be gently asked whether they are happy to attend the next session. The question **'Are you happy to come to the 'FRIENDS Club' next week**?' will be asked informally when the materials are being tidied up. Both the researcher and the LST can ask the questions ensuring that each child is only asked once and that a clear response, verbal or non-verbal, is received from the child.

(c)Happy to continue in intervention:

Should the child indicate that they are happy to attend the next session then this will be discussed at the weekly review meeting and communicated to parents who will have been asked to check with their child about how they are feeling about the 'FRIENDS Club'. Should the parents indicate that their child is happy to attend then a decision is made to maintain the child in the intervention.

(d) Not happy to continue:

Should a child indicate that they are not happy to attend the next session then it will be indicated to the child that this is perfectly OK. This must be communicated carefully so as not to convey any sense of disappointment to the child. The child's decision will be discretely communicated to the class teacher as soon as possible. The child's decision will be communicated calmly to parents by telephone call as soon as possible. A review meeting will be held and the parents will be invited to attend. Decisions on how to proceed will be made by the group.

(e) The child's response to the question: 'Are you happy to come to the 'FRIENDS Club' next week?' is unclear.
If the child's response to question 'Are you happy to come to the *FRIENDS Club* next week?' is unclear, then the class teacher will be asked to check as soon as possible before the weekly review meeting. The child's response will be discretely communicated to parents and subsequently discussed at the weekly review meeting to which they are welcome. A decision on whether to invite the child to the next session will be made by the group.

(f) Any other signs of reluctance, discomfort or increased anxiety will be shared by members of the project team at the weekly review meetings and decisions will be made on how to proceed ensuring that the child's care and safety remain central to the discussions.

Appendix 14 Second and third round focused codes and study concepts

2nd round focused code	**3rd round focused codes**	**Study concepts**		
	Study themes	**Application**	**Programming**	**Cognitive-ecological**
Anxiety Identification	Anxiety	✓		✓
Relaxation				
Visualisation		✓	✓	
Family Similarity				✓
Teaching anxious children			✓	✓
School related anxiety		✓		✓
Child's interests	Child	✓	✓	✓
Child wellbeing		✓		
Children's participation		✓	✓	
Children's awareness			✓	✓
Children's relationships			✓	✓

Friendship			✓	
Care and Safety	Ethical	✓	✓	✓
Parent as negative model				✓
Parent judgement	Parent		✓	
Parent supporting project			✓	
Parent/child relationship			✓	
Parental wellbeing				✓
Parents' awareness		✓		✓
Parents' sensitivity to difference			✓	✓
Parent values				✓
Parent as advocate				✓
Seeking insight				✓
Partnership	Therapeutic relationship (PRECISE principles)	✓	✓	
Right developmental level		✓	✓	
Empathy		✓	✓	
Creative			✓	
Investigation and experimentation		✓	✓	
Self-discovery and self efficacy		✓	✓	
Enjoyable		✓	✓	
Establishing a rationale		✓		
FFL programme	Programme implementation		✓	
Parent as positive model				✓
Physical elements		✓		
Programme concepts			✓	
Programme delivery		✓	✓	
Universal simultaneous to target		✓		✓

Support for programme		✓		✓
Stages of change		✓	✓	✓
Teacher communicating with participants		✓	✓	✓
Barriers to support		✓		✓
Research process	Research process	✓	✓	
Researcher Reflection		✓	✓	
Screening process		✓	✓	
Teacher as advocate	Teacher	✓	✓	✓
Teacher judgement		✓	✓	✓
Teacher monitoring		✓	✓	✓
Teacher valuing		✓		✓
Verbal output	Impact		✓	
Non-verbal participation		✓	✓	
Normalising		✓	✓	
Increased confidence			✓	
Children's perception of FRIENDS programme			✓	
Social connectivity		✓		
Classroom management	School		✓	✓
School management				✓
School Openness		✓	✓	✓

Appendix 15 Millie's Small Steps Plan (Lesson 9)

1. Hi Millie here again. As you know I have lots of worries from time to time. I have learned ways to cope with these worries. I am learning how to pay attention to happy things, to change red thoughts to green thoughts and to use breathing to help me relax.

2. Here is a picture of me with all the skills I have learned to use to cope with my worries.

3. Pre-contemplation:

   Remember Mike? He used to worry about where to sit on the bus. It took him a while to realise that things could be different. He used his breathing to get from a 5 to a 1 when his worries got too big. He's brilliant doing this.

4. I too can make things different. I can be brave like Mike, and not let worries hold me back.

5. I can find out what I would like to change by asking myself some questions like:

   Contemplation

a. It there anything at home or school that I would like to be more brave at doing?

b. Am I ready to be braver?

c. What are my biggest worries at the moment?

6. Preparation: Goals

   So I picked one thing I wanted to be different. I wanted to be more brave and confident doing this thing.

7. I called this thing 'My Goal' Here is a picture of me reaching my goal. I wanted to be brave enough to knock on my friend's door and ask if she could bring my dog for a walk with me.

8. Action: I came up with a plan. I call it a Small Steps Plan or SSP.

9. Mike's goal was to bring his 5 feeling down to a 1 or a 2 as the bus arrived. I have a few goals of my own.

10. When I try to reach a goal I use an SSP a Small Steps Plan.

11. I don't pick the hardest thing from my list to start with.

12. I pick something that is challenging that I think I could try my best to do.

13. I pick something I can control myself or with the help of my family my teacher or my friends.

14. I work out the small steps for my SSP and a helpful thought for each step.

15. Best of all I like to give myself a reward when I reach my goal. 16. I love SSPs

Appendix 16 *FRIENDS* Club activities

These are some of the things we did in the FRIENDS CLUB. You can add to this list if you remember other things we did.

	What did you think of the activities we did in *FRIENDS* Club?	Give it a 5 if you really liked it 4 if you liked it 3 if it was OK 2 if you didn't like it 1 if you really didn't like it.
1	We heard about FRIENDS from teacher	
2	Playing with Talking Mats	
3	Making rules for the CLUB	
4	We wrote list of things to do on the whiteboard	
5	Ms. XXXX watched us work sometimes	
6	We sat in an L shape	
7	Relaxation on the mat	
8	Using pictures to learn about feelings	
9	Picking our favourite pictures for relaxation	
10	Using 'My Happy Cards'	
11	Doing Robots Towers and Jellyfish	
12	We learned to think about unhelpful red thoughts and helpful green thoughts	
13	Sometimes we worked in the classroom with the whole class	
14	Learning to use challenger questions	
15	We brought books and a guitar to the group	
16	We learned about how Mike managed his worries	
17	We changed positions some weeks	
18	Millie Stories	
19	Setting goals	
20	Making stories about her 5 Block problem solving plan	
21	We used our TM boards to practice	
22	Making a TV programme with the whole class	
24	We learned about body clues	

1. Now that the FRIENDS CLUB is over please tell me what is was like to be in it?
2. Tell me about the things you enjoyed the most?
3. Tell me about what was not enjoyable?
4. Do you think it helped you at school?
5. Do you think it helped you outside school
6. How could we make it better for the next FRIENDS CLUB group?

Results of Survey of FRIENDS Club activities

15 Points	14 Points	13 Points	12 Points
Relaxation on the mat	Making a TV programme with the whole class	Using pictures to learn about feelings	Playing with Talking Mats
Picking our favourite pictures for relaxation	Doing Millie Stories	Setting goals	Making rules for the CLUB
Using 'My Happy Cards'	Learning about how Mike managed his worries	Making stories about our 5 Block problem solving plan	Learning to change unhelpful red thoughts into helpful green thought
Learning to use challenger questions			Working in the classroom with the whole class on FFL

Appendix 17 Elements of Assent

'Alongside beneficence, non-maleficience, justice and respect for persons, the fundamental principle underlying informed consent is self-determination. (Lambert and Glacken, 2011, 783)

The class teacher will privately explain the project to each child proposed for the intervention and invite them to meet individually with the researcher and their teacher after school on an assigned day for an information sharing session. This meeting will be signalled by telephone to parents in advance.

At this meeting the researcher and school principal will share with the children's the project information sheet (c.f. Appendix 14). This information sheet and other documents used with the children will be written in developmentally appropriate language using enlarged print (14) and incorporate diagrams and pictures to convey the purpose and nature of the study. The project's risks and benefits, confidentiality and privacy arrangements, the option to withdraw, child protection issues and researcher contact details will be included.

The principal, who has an existing relationship with the children, will help the researcher to judge whether the children are fully informed and capable of giving their assent (i.e. agreement) to participate.

Elements of Assent (Lambert and Glacken, 2011) which will be considered include:

A: Assess child's capacity/ readiness to assent within a context of rapport building.

S: Supply the child with adequate and comprehensible verbal and written information.

S: Search for signs of refusal (subtle or obvious) and ensure no pressure is applied.

E: Evaluate evidence of the child's understanding through questions and feedback

N: Negotiate assent continuously.

T: Time is allocated to the child to think about whether to participate, or not.

'Some children suffering from fearfulness or anxiety are difficult to form rapport with'(Jones, 2003:45). A number of implications for practice with anxious children arise and these include a very basic essential of knowing as much as possible about the psychological condition before engagement. This information will be sought form parents in advance.

Jones advises that it is best to be gentle, yet clear and sensitive to the effect of eye-contact. It may be difficult for disturbed children to tolerate direct eye-contact. It is necessary to go at the child's pace.

The researcher will maintain an awareness of the following core professional skills and qualities to communicate effectively with children which include:

- Listening to the child
- Conveying genuine interest
- Showing empathic concern
- Showing understanding
- Showing emotional warmth
- Showing respect for the child
- Showing a capacity to manage and contain the discussion
- Showing an awareness of the entire transaction between the interviewer and child
- Using suitable communication methods. Symbols can be used to facilitate communication at this stage if necessary.

The teacher and researcher will have explained the FRIENDS programme and to all upper grade children and this should help to normalise the project for the intervention group children within the school. Should the children raise the question 'How should I explain the project to the others in my class or in the school or outside of school?' then the teacher, the researcher and the children can draw up a short verbal script to use.

The children's activities in the 'FRIENDS Club' during the sessions will be explained in terms of practising skills and using symbols to show their preferences.

With these reluctant or uncommunicative children Jones (2003) recommends allowing additional time and even several rapport -building sessions. Readiness to participate will be judged by the teacher, researcher and parent in advance of beginning any intervention work.

Competence, information and voluntary-ness will form the three key elements in the decision between the teacher, the child and the researcher as to whether the consent of each child is valid at this stage.

Should the child's consent be judge to be valid then the '*O.K.- Assent Form for Children'* (c.f. Appendix) will be presented and explained , and the child will be invited to sign to indicate their consent to participate in the 'FRIENDS Club'

This consent to participate will be viewed as an on-going process and not viewed as a mere one off event. In this regard verbal assent will be renegotiated on a sessional basis in an informal manner (e.g.' Hi Mary. How are you keeping? Are you happy to stay and take part in the FRIENDS Club today?').

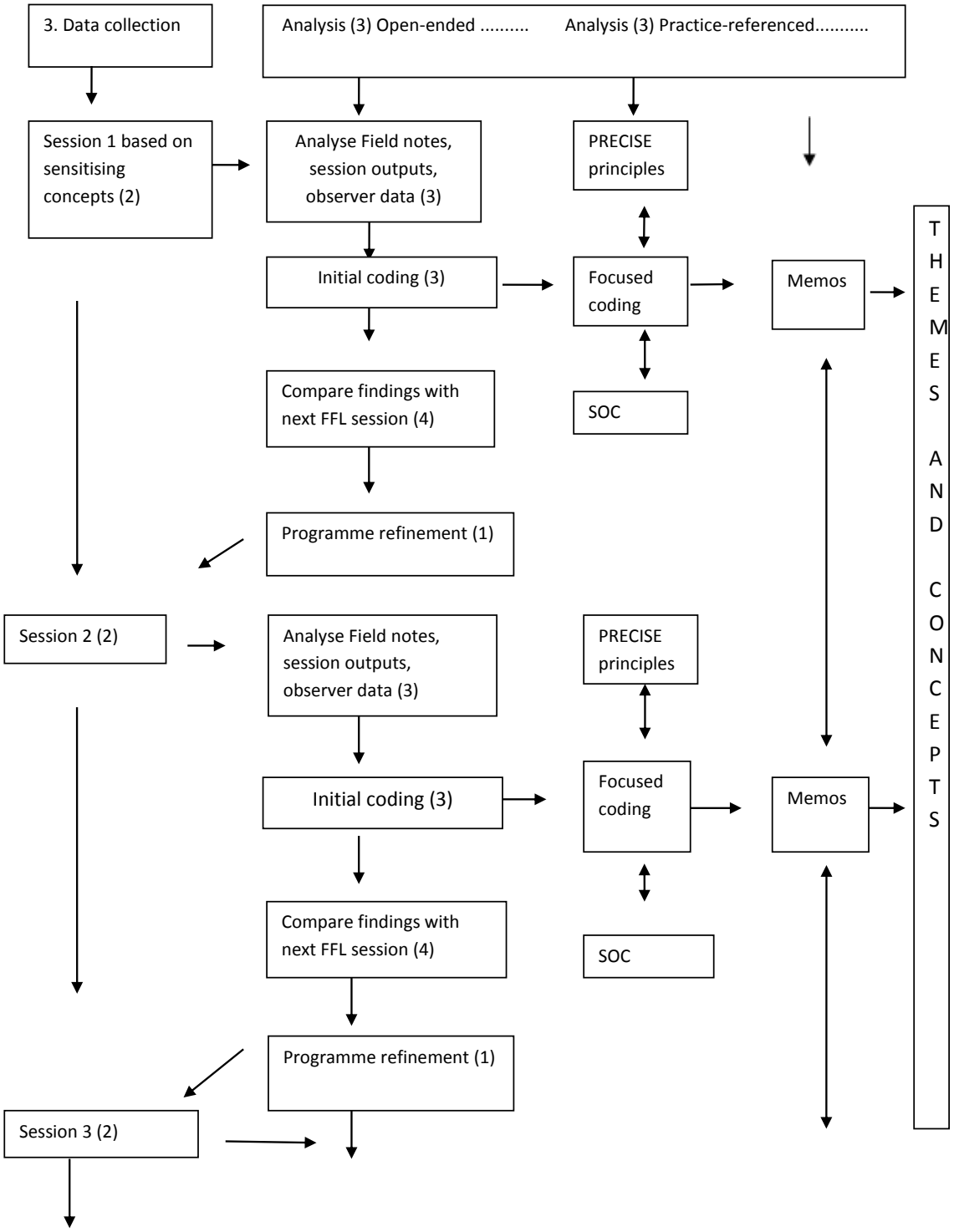
It is important to close the information sharing session(s) well and not to end in disarray.

Each child has a right to withdraw

Children will be told that the decision to take part is theirs alone and that should they wish to withdraw from the project at any time that this is 'OK', and that 'no one will be mad with them'. They can withdraw at any time by saying so or by raising the 'I want to Stop' card

In any such case where a child withdraws the researcher and the teacher will, as soon as possible and in private, discuss whether any of their actions (i.e. the teachers' actions or the researcher's actions), event at school or elsewhere has contributed to the decision to withdraw and whether a change in approach might help the participants to continue. In most cases though the researcher will quickly accept the participant's decision to withdraw and no pressure to continue will be applied.

APPENDIX 18 Data analysis process



APPENDIX 19 Scales used in the study

(1) Spence Children's Anxiety Scales (SCAS) (Spence, 1998)

The SCAS (c.f. Appendix 21) is a widely used scale within the NEPS service. It comprises forth four items, thirty eight pertaining to specific kinds of anxiety with six 'filler' questions to reduce the potential for negative response bias. Responses to statements about anxiety are indicated on a scale ranging from 0 (never) to 4 (always). The responses are summed to an overall score, with higher scores indicating anxiety.

The scale was normalised on a sample of 4,916 Australian children, aged 8-15 years. It has been used extensively in other countries including RoI particularly in the context of pre and post measures for interventions with children. The internal reliability of the scale has been found to be high for test-retest reliability.

(2) Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997)

The SDQ (c.f. Appendix 22) is a screening questionnaire used with CYP aged 4-16 years. It examines twenty five behavioural attributes, which are broken down into five categories: conduct disorder, hyperactivity, emotional symptoms, peer problems and pro-social behaviour. Scoring is on a 0 (not true) to 2 (certainly true) basis with high scores on the initial four scores representing difficulties and high scores on the pro-social subscale representing strengths. The SDQ was standardised in the UK in a national survey of child and adolescent mental health; this sample consisted of 10,483 participants aged 5-15 years. Its potential has been recognised for the identification of child psychiatric conditions, including emotional disorders (Goodman, Renfrew and Mullick, 2000). Goodman (2001) found the reliability of the instrument to be reliable.

(3) Behavioural Assessment Scale for Children (2^{nd} Ed)

The Behaviour Assessment Scale for Children, Second Edition (BASC-2 Reynolds and Kamphaus, 2004) is used widely in the assessment of behavioural and mood concerns such as symptoms of anxiety, depression and ADHD. The scale uses a suite of scales to gain a triangulated measure of behaviour from parent, teacher and child self-report forms. The scale has been described as a multi-method and multidimensional assessment. It is also useful for the evaluation of children, adolescents, and young adults, ages two to twenty five years of age (Reynolds & Kamphaus, 2004).

In order to gather adequate assessment data, this tool uses various components to measure multiple dimensions of the child. This assessment measure consists of five components that can either be used in combination or separately. The five components include: (a) the Teacher Rating Scales (TRS), (b) the Parent Rating Scales (PRS), (c) the Self-Report of Personality (SRP), (d) the Structured Developmental History (SDH) form, and (e) the Student Observation System (SOS). The TRS and the PRS use a 4-point response format (N for Never, S for Sometimes, O for Often, or A for Almost Always).The adding of the points provides a raw score, which is converted into a normative score. A *T*-score on the BASC-2 delegates the distance of a raw score from the norm-group mean. In addition, a percentile rank indicates the percentage of the norm sample scoring below a given raw score.

The BASC has been used in several longitudinal studies exploring: (1) risk, onset, course, and progression of behavioural problems and psychopathology, (2) the predictive validity of early temperament, (3) the identification of adolescents who may benefit from residential treatment centres, and (4) the resulting effects of school violence prevention programs (Reynolds & Kamphaus, 2004). The scales and composites have high internal consistency and test-retest reliability. Construct validity, for the internalizing and externalizing dimensions of the BASC scales are supported by the results of a factor analyses and structural equation analysis. Criterion-related validity of the scales is satisfactory. The standardization sample closely matches the 2001 U.S. Census data with regard to gender, race/ethnicity, clinical or special education classification. Items were analysed to ensure similar behaviour for both sexes and minorities.

Appendix 21 Spence Children's Anxiety Scale

Appendix 6

SPENCE CHILDREN'S ANXIETY SCALE

Your Name: _____ **Date:** _____

PLEASE PUT A CIRCLE AROUND THE WORD THAT SHOWS HOW OFTEN EACH OF THESE THINGS HAPPEN TO YOU. THERE ARE NO RIGHT OR WRONG ANSWERS.

1.	I worry about things	Never	Sometimes	Often	Always
2.	I am scared of the dark	Never	Sometimes	Often	Always
3.	When I have a problem, I get a funny feeling in my stomach	Never	Sometimes	Often	Always
4.	I feel afraid	Never	Sometimes	Often	Always
5.	I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
6.	I feel scared when I have to take a test	Never	Sometimes	Often	Always
7.	I feel afraid if I have to use public toilets or bathrooms	Never	Sometimes	Often	Always
8.	I worry about being away from my parents	Never	Sometimes	Often	Always
9.	I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
10.	I worry that I will do badly at my school work	Never	Sometimes	Often	Always
11.	I am popular amongst other kids my own age	Never	Sometimes	Often	Always
12.	I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
13.	I suddenly feel as if I can't breathe when there is no reason for this	Never	Sometimes	Often	Always
14.	I have to keep checking that I have done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
15.	I feel scared if I have to sleep on my own	Never	Sometimes	Often	Always
16.	I have trouble going to school in the mornings because I feel nervous or afraid	Never	Sometimes	Often	Always
17.	I am good at sports	Never	Sometimes	Often	Always
18.	I am scared of dogs	Never	Sometimes	Often	Always
19.	I can't seem to get bad or silly thoughts out of my head	Never	Sometimes	Often	Always
20.	When I have a problem, my heart beats really fast	Never	Sometimes	Often	Always
21.	I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
22.	I worry that something bad will happen to me	Never	Sometimes	Often	Always
23.	I am scared of going to the doctors or dentists	Never	Sometimes	Often	Always
24.	When I have a problem, I feel shaky	Never	Sometimes	Often	Always
25.	I am scared of being in high places or lifts (elevators)	Never	Sometimes	Often	Always

26.	I am a good person	Never	Sometimes	Often	Always
27.	I have to think of special thoughts to stop bad things from happening (like numbers or words)	Never	Sometimes	Often	Always
28	I feel scared if I have to travel in the car, or on a Bus or a train	Never	Sometimes	Often	Always
29.	I worry what other people think of me	Never	Sometimes	Often	Always
30.	I am afraid of being in crowded places (like shopping centres, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
31.	I feel happy	Never	Sometimes	Often	Always
32.	All of a sudden I feel really scared for no reason at all	Never	Sometimes	Often	Always
33.	I am scared of insects or spiders	Never	Sometimes	Often	Always
34.	I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
35.	I feel afraid if I have to talk in front of my class	Never	Sometimes	Often	Always
36.	My heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
37.	I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
38.	I like myself	Never	Sometimes	Often	Always
39.	I am afraid of being in small closed places, like tunnels or small rooms.	Never	Sometimes	Often	Always
40.	I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
41.	I get bothered by bad or silly thoughts or pictures in my mind	Never	Sometimes	Often	Always
42.	I have to do some things in just the right way to stop bad things happening	Never	Sometimes	Often	Always
43.	I am proud of my school work	Never	Sometimes	Often	Always
44.	I would feel scared if I had to stay away from home overnight	Never	Sometimes	Often	Always
45.	Is there something else that you are really afraid of?	YES	NO		
	Please write down what it is_____				
	_____				
	_____				
	How often are you afraid of this thing?	Never	Sometimes	Often	Always

APPENDIX 22 Strengths and Difficulties Questionnaire

Appendix 22
TEACHER

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months or this school year.

Child's Name ..... Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Signature ..... Date .....

Parent/Teacher/Other (please specify:)

Thank you very much for your help

Appendix 22A PARENTS

Strengths and Difficulties Questionnaire

P 4-16

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name ..... Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Appendix 22 A PARENTS

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help

Appendix 23 Effectiveness framework of functional communication

	Always (4)	Often (3)	50:50 (2)	Occasionally (1)	Never/none (0)
Engagement		Yes			
Participant's understanding	Yes				
Interviewer's understanding of child's view	Yes				
Participant on track		Yes			
Symmetry				Yes	
Real time			Yes		
Interviewer's chill factor			Yes		
Total Score (19)	**8**	**6**	**4**	**1**	